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Neil Vidmar

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# MEDICAL MALPRACTICE LAWSUITS: AN ESSAY ON PATIENT INTERESTS, THE CONTINGENCY FEE SYSTEM, JURIES, AND SOCIAL POLICY

*Neil Vidmar\**

## I. INTRODUCTION

This Essay is intended to provide laypersons a selected perspective on one of the most contentious subjects in American civil law, namely lawsuits against doctors and hospitals involving claims of medical negligence. It is written at a time when the American Medical Association and other doctors' organizations, businesses groups such as the American Chamber of Commerce, politicians, and mass media have declared a lawsuit crisis.<sup>1</sup> Those groups are calling for "tort reform" to cure or at least ameliorate the crisis.<sup>2</sup>

The subject is highly contentious and complicated.<sup>3</sup> Among

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\* Russell M. Robinson, II Professor of Law and Professor of Psychology, Duke Law School. This article was supported, in part, by a grant from the Provost's Common Fund of Duke University. The opinions expressed in the article are solely those of the author and do not necessarily reflect any position of Duke University. I am grateful to Donald Beskind and Joanne Ernteman, Dr. Daniel Hoffman, and Herbert Kritzer for comments on earlier drafts of the article.

1. See, e.g., Politically Active Physicians Association, at <http://www.fightingdocs.com> (last visited Aug. 1, 2005); Ceci Connolly, *Cheney Urges Caps on Malpractice Awards*, WASH. POST, July 20, 2004, at A6; Rich Lowry, *Suing the OB-GYNs: Our Legal System Doesn't Exactly Welcome Life Into the World*, at <http://www.nationalreview.com/lowry/lowry200408201007.asp> (Aug. 20, 2004).

2. See *supra* note 1.

3. David M. Studdert et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283 (2004), provide an excellent review of the history of contemporary problems of medical liability insurance. See also NEIL VIDMAR, *MEDICAL MALPRACTICE AND THE AMERICAN JURY: CONFRONTING THE MYTHS ABOUT JURY INCOMPETENCE, DEEP POCKETS, AND OUTRAGEOUS DAMAGE AWARDS* (1995).

other topics it involves issues about compensation of patients, about the ability of the American tort system to separate meritorious claims from non-meritorious claims, about the degree to which the threat of lawsuits deters negligent medical errors or causes doctors to engage in defensive medicine, and about the effects of lawsuits on liability insurance premiums and ultimately the access Americans have to health care.<sup>4</sup>

This Essay is limited in its scope and presents only one part of this complicated social and economic problem, so it is essential to make one thing clear. *This Essay does not take issue with the claim of the American Medical Association and other parties urging "tort reform" that, beginning about the year 2000, some physicians began experiencing severe difficulties in obtaining affordable medical liability insurance.*<sup>5</sup> The public debate involves the cause of the problem.

Proponents of tort reform, particularly health care providers and business organizations, blame the tort system as the principal culprit.<sup>6</sup> They say that both the frequency of claims and average amounts of medical negligence claims payments increased over the years<sup>7</sup> and that juries tend to favor plaintiffs and give excessive verdict awards.<sup>8</sup> They also believe that the "shadow effect" from large jury awards inflates the size of settlements because the risk of being subjected to excessive awards forces insurers to settle cases that may otherwise be defensible.<sup>9</sup> Finally, they believe that the contingency fee system provides a "lottery" effect that contributes to

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4. See Studdert et al., *supra* note 3; Michelle M. Mello et al., *The New Medical Malpractice Crisis*, 348 NEW ENG. J. MED. 2281 (2003); Peter Akmajian, *A Fair and Balanced Look at Tort Reform*, FOR THE DEFENSE, Nov. 2004, at 33.

5. See Studdert et al., *supra* note 3; Press Release, American Medical Association, Wyoming Becomes 19th State in Medical Liability Crisis (Oct. 6, 2003) (on file with Loyola of Los Angeles Law Review) [hereinafter American Medical Association]; U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE, GAO-03-836 (2003).

6. See, e.g., Stuart Taylor Jr. & Evan Thomas, *Civil Wars*, NEWSWEEK, Dec. 15, 2003, at 43, 46-48; Lowry, *supra* note 1; see also VIDMAR, *supra* note 3 (describing similar claims made a decade earlier).

7. Studdert et al., *supra* note 3.

8. Taylor & Thomas, *supra* note 6, at 51.

9. *Id.* at 48.

the filing of frivolous lawsuits since some insurers may settle suits for an amount less than the costs of mounting a defense.<sup>10</sup> In the process plaintiff lawyers, they say, earn unjustified fees.<sup>11</sup>

Consumer organizations and plaintiff trial lawyers claim that the problem is not with the tort system.<sup>12</sup> Instead, they say the problem has several sources. First, there is a high incidence of negligent medical mistakes that lead to legitimate claims.<sup>13</sup> Many claims involve serious injuries, and patients suffer large medical and income losses.<sup>14</sup> They also contest the assertions that claim frequency is increasing and that the awards to plaintiffs are inappropriate.<sup>15</sup> They contend that the real cause of rising malpractice premiums has several sources.<sup>16</sup> During the 1990s, they say, the liability insurance companies underpriced the premiums they charged doctors as they competed with one another for business.<sup>17</sup> The companies then used poor investment strategies.<sup>18</sup> The problems were exacerbated when there was a downturn in the bond market where insurers invested their reserves.<sup>19</sup> These groups predict that the problems are temporary—a downturn in the business cycle that will shortly correct itself as it did in previous liability insurance crises in the 1970s and 1980s.<sup>20</sup>

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10. See generally Joseph T. Hallinan, *In Malpractice Trials, Juries Rarely Have the Last Word*, WALL ST. J., Nov. 30, 2004, at A1 (discussing how plaintiffs settle with insurance companies on a predetermined amount to “protect one person from getting a run-away verdict and . . . the other from getting nothing”).

11. Taylor & Thomas, *supra* note 6, at 45.

12. CTR. FOR JUSTICE & DEMOCRACY, *THE EIGHT BIGGEST MYTHS ABOUT MEDICAL MALPRACTICE—AND HOW TO RESPOND* (2003), available at <http://centerjd.org>.

13. CTR. FOR JUSTICE & DEMOCRACY, *A SHORT GUIDE TO UNDERSTANDING TODAY’S MEDICAL MALPRACTICE INSURANCE “CRISIS”* 14, at <http://www.centerjd.org/MediaGuide.pdf> (Sept. 25, 2002).

14. INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH CARE SYSTEM* (Linda Kohn et al. eds., 2000), [http://books.nap.edu/catalog/9728.html?onpi\\_newsdoc112999](http://books.nap.edu/catalog/9728.html?onpi_newsdoc112999); Lucian L. Leape, *Institute of Medicine Medical Error Figures Are Not Exaggerated*, 284 J. AM. MED. ASS’N 95 (2000).

15. CTR. FOR JUSTICE & DEMOCRACY, *supra* note 13, at 12.

16. *Id.* at 7.

17. *Id.* at 9.

18. *Id.*

19. CTR. FOR JUSTICE & DEMOCRACY, *supra* note 12.

20. CTR. FOR JUSTICE & DEMOCRACY, *supra* note 13, at 7.

This Essay draws attention to the fact that the public debate about medical malpractice tort reform largely ignores the problems of patients injured through medical negligence. This Essay explains the processes by which those patients seek compensation through lawyers and the contingency fee system. Also, the Essay confronts widely held beliefs about irresponsible juries, frivolous lawsuits, and greedy or vindictive patients. Attention is drawn to the fact that the burden of negligently injured patients often falls upon American taxpayers through their funding of Medicare, Medicaid, and other welfare agencies. This latter insight raises an undiscussed public policy issue in the tort reform debate, namely whether taxpayers or the negligent health care provider should bear the burden of medical malpractice.

By describing the origin and process of medical malpractice litigation and by confronting some widely accepted notions about the litigation system lay readers will hopefully gain a better understanding of a largely neglected side of the medical malpractice debate. Yet, they need to keep in mind that there are two sides to the debate about medical malpractice, that researchers' knowledge bases are incomplete, and that the inability of health care providers to obtain affordable professional liability insurance can have major societal consequences. In the concluding section the Essay briefly addresses some of the additional issues.

## II. THE INCIDENCE AND COSTS OF MEDICAL NEGLIGENCE

Sometimes explicitly, but more often tacitly, debates about medical malpractice contain the arguments that medical negligence is relatively infrequent<sup>21</sup> and that injuries and the consequent financial losses of patients are exaggerated.<sup>22</sup>

### *A. Medical Injury Due to Negligence Is Not Infrequent*

A Harvard study of medical negligence examined hospital records of 31,000 patients and concluded that one out of every 100 patients admitted to hospital had an actionable legal claim based on

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21. See, e.g., PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 124-29 (1993) (reporting that doctors tend to admit that injuries occur but are reluctant to ascribe the result to negligence).

22. Taylor & Thomas, *supra* note 6, at 45.

medical negligence.<sup>23</sup> Some of these patients' injuries were minor or transient, but fourteen percent of the time the adverse event resulted in death and ten percent of the time the incident resulted in hospitalization for more than six months.<sup>24</sup> Furthermore, seven of those ten persons suffered a permanent disability.<sup>25</sup> Generally, the more serious the injury the more likely it was caused by negligence.<sup>26</sup> Subsequent research involving Utah and Colorado found rates of negligent adverse events that were similar to the New York findings.<sup>27</sup> These findings are consistent with earlier research reported by Patricia Danzon who estimated that on average one in twenty hospital patients incurred an injury due to medical error.<sup>28</sup> A still earlier study in California estimated that compensable injuries due to negligence occurred in one in 125 hospitalizations.<sup>29</sup> In 2000, The Institute of Medicine produced a report that relied on these studies and other data.<sup>30</sup> It concluded that each year 98,000 persons die due to medical negligence and that many other patients sustain serious injuries.<sup>31</sup>

There are reasons to believe that the Harvard study may have underestimated the incidence of medical negligence. That is, the Harvard data were based on hospital records. Lori Andrews conducted a study in a large Chicago area hospital, and studied actual incidence of negligent events in hospital wards.<sup>32</sup> Andrews discovered that many injuries were not recorded on the records as required, especially when the main person responsible for the error was a senior physician.<sup>33</sup> Other research is consistent with the

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23. WEILER ET AL., *supra* note 21, at 124–29.

24. *Id.* at 44.

25. *Id.*

26. *Id.* at 44, tbl.3.2.

27. Eric J. Thomas et al., *Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado*, 38 MED. CARE 261, 261 (2000).

28. PATRICIA M. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 20 (1985).

29. CALIFORNIA MEDICAL ASSOCIATION, *MEDICAL INSURANCE FEASIBILITY STUDY* (Donald Mills ed., 1977).

30. INSTITUTE OF MEDICINE, *supra* note 14; Leape, *supra* note 14.

31. *Id.*

32. LORI B. ANDREWS, *MEDICAL ERROR AND PATIENT CLAIMING IN A HOSPITAL SETTING* (Am. Bar Found., Working Paper No. 9316, 1993); Lori Andrews, *Studying Medical Error in Situ: Implications for Malpractice Law and Policy*, 54 DEPAUL L. REV. 357 (2005).

33. *Id.*

Andrews findings.<sup>34</sup> For example, in one study Dr. Thomas Julian had a panel of obstetricians review obstetric malpractice claims.<sup>35</sup> He concluded that "common obstetrical risks were often not recognized or not recorded in medical records."<sup>36</sup>

In 2004, Healthgrades, Inc., a company that rates hospitals on health care for insurance companies and health plans, studied Medicare records in all fifty states for the years 2000 to 2002.<sup>37</sup> Healthgrades concluded that the Institute of Medicine's figure of 98,000 deaths was too low and that a better estimate was 195,000 annual deaths.<sup>38</sup> In addition, it estimated that there were 1.14 million "patient safety incidents" among thirty-seven million hospitalizations.<sup>39</sup> Healthgrades further concluded that "[o]f the total 323,993 deaths among Medicare patients in those years who developed one or more patient-safety incidents, 263,864, or 81 percent, of these deaths were directly attributable to the incidents" and that "[o]ne in every four Medicare patients who were hospitalized from 2000 to 2002 and experienced a patient-safety incident died."<sup>40</sup>

There are criticisms that the estimates from these various studies are too high.<sup>41</sup> There is no serious question, however, that medical negligence not only occurs, but that it occurs at a substantial rate.

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34. See Leape, *supra* note 14, at 97 (citing R.W. DuBois and R. Brook, *Preventable Deaths: Who, How Often and Why?* 109 ANNALS INTERNAL MED. 582 (1988); Kathryn B. Kirkland et al., *The Impact of Surgical-Site Infections in the 1990s: Attributable Mortality, Excess Length of Hospitalization, and Extra Costs*, 20 INFECTION CONTROL & HOSP. EPIDEMIOLOGY 725 (1999).

35. Thomas M. Julian et al., *Investigation of Obstetric Malpractice Closed Claims: Profile of Event*, 2 AM. J. PERINATOLOGY 320 (1985).

36. *Id.*

37. Reuters News, *Report Says 195,000 Deaths Due to Hospital Error* (July 27, 2004), WL 7/27/04 Reuters Eng. News Serv. 22:23:11.

38. *Id.*

39. *Id.*

40. *Id.*

41. For criticism of the Harvard study or controversy over some of the findings, see Rodney A. Hayward & Timothy P. Hofer, *Estimating Hospital Deaths Due to Medical Errors*, 286 J. AM. MED. ASS'N 415 (2001); Clement J. McDonald et al., *Deaths Due to Medical Error Are Exaggerated in Institute of Medicine Report*, 284 J. AM. MED. ASS'N 93 (2000).

*B. Injuries Due to Medical Negligence Have High Costs*

One only needs to consider an illustration or two in order to appreciate the cost of a serious injury.<sup>42</sup> For example, a woman in her forties, divorced, with two dependent children, entered a hospital with a high fever. A tube was improperly inserted into her lung, necessitating partial removal of the lung. In the recovery room, bleeding from the surgery was discovered, and she was rushed back to the operating room where another tube was improperly inserted in her other lung. The woman became paralyzed from the chest down and will have to spend the rest of her life in a nursing home. What will be the cost of her medical care and lost income for the next three or more decades? As a second example, what is the cost associated with a child born blind, deaf, and retarded, and requiring constant attention to avoid bed sores and other illnesses, especially when experts predict that she could live for decades?

More than a dozen years ago Frank Sloan and Stephen van Wert, two economists, conducted systematic assessments of economic losses (medical costs, income losses, and other expenses) in Florida cases involving claims of medical negligence occurring as a result of birth-related incidents.<sup>43</sup> Even though those researchers offered the caution that their assessment procedures probably underestimated losses,<sup>44</sup> severely injured children's economic losses were, on average, between \$1.4 and \$1.6 million in 1989 dollars.<sup>45</sup> If adjusted for inflation using the consumer price index, these figures in 2004 dollars translate roughly to \$2.25 million.<sup>46</sup> In the same study the

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42. Both of the examples that follow are based on cases from the data set analyzed in VIDMAR, *supra* note 3.

43. Frank A. Sloan & Stephen S. van Wert, *Cost of Injuries*, in FRANK A. SLOAN ET AL., *SUING FOR MEDICAL MALPRACTICE* 123, 139–40 (1993).

44. *Id.* at 145.

45. *Id.* at 138.

46. See Robert C. Sahr, *Consumer Price Index (CPI) Conversion Factors 1800 to Estimated 2014 to Convert Dollars of 2001*, Oregon State University, at [http://www.orst.edu/Dept/pol\\_sci/fac/sahr/cv2001.pdf](http://www.orst.edu/Dept/pol_sci/fac/sahr/cv2001.pdf) (Mar. 1, 2004). However, inflation in medical costs is generally higher than the consumer price index. See <http://www.halfhill.com/inflation.html>; U.S. Dep't of Labor, *Medical Care Inflation Continues to Rise*, MONTHLY LABOR REV., at <http://www.bls.gov/opub/ted/2001/May/wk4/art01.htm> (May, 29, 2001) (documenting the increase in the Consumer Price Index for medical care from 1991–2000). Thus, conversion by the CPI underestimates economic losses by



losses of persons who survived an emergency room incident were estimated at \$1.3 million,<sup>47</sup> or \$ 2.1 million in 2004 dollars. For persons who died in an emergency room incident the loss to their survivors was estimated at \$0.5 million,<sup>48</sup> or \$0.8 million in today's dollars. It is important to note that there was considerable variability in these estimated averages: some patients had much higher economic losses and, conversely, others had lesser economic losses.<sup>49</sup>

Sloan and van Wert cautioned that a major share of past losses was covered by collateral sources, such as private health insurance, or taxpayer-supported sources such as Medicare.<sup>50</sup> Even if future medical expenses, including nursing care, are covered by these other sources, loss of income and other expenses—such as care given by family members resulting in diminished income from those family members—will not be covered.<sup>51</sup> Sloan and van Wert's estimates, moreover, did not consider non-economic losses, such as pain and suffering, disfigurement, or loss of enjoyment of life's amenities.<sup>52</sup>

*C. Non-Economic Losses (i.e., "Pain and Suffering") as a Component of Awards*

There are some injuries that are very harmful to the patient but defy ordinary economic accounting. At a recent congressional hearing<sup>53</sup> Heather Lewinski, a seventeen-year-old teenager, courageously testified about her psychological pain as a result of egregious medical malpractice when she was eight years old that left her face permanently and horribly disfigured. Among other side-effects, she constantly drools. She described how other children made fun of her as she advanced through her teenage years. She had one self-initiated date, and it was a disaster. She told about her belief that she will never marry, will never have children, and will have to

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some unknown degree.

47. Sloan & van Wert, *supra* note 43, at 140.

48. *Id.*

49. *Id.* at 137, 142.

50. *Id.* at 145.

51. *Id.*

52. *See id.*

53. *The Medical Liability Insurance Crisis: A Review of the Situation in Pennsylvania, Before the Subcomm. on Oversight and Investigations of the Comm. of Energy and Commerce*, 108th Cong. 60 (2003).

concentrate on raising and training dogs because they do not discriminate on the basis of human appearances. Unfortunately, despite her apparent intelligence, warm personality, and the unfairness of her condition, Heather is probably right—I saw her face, as did others who tearfully heard her testimony. If Heather lives to be seventy-eight years old, an award of \$250,000—the limit for non-economic damages in many tort reform packages—would compensate her at the rate of \$3,571 per annum for her shattered life.<sup>54</sup>

Heather's story is not the only example of patients' injuries defying economic accounting. When I was conducting research in North Carolina, a young mother of two children was rendered permanently blind. In other cases patients lost sexual or reproductive functions, injuries that were very real, but the losses could not be easily calculated like medical expenses or loss of income.

There is often conceptual confusion in the mind of the public about non-economic damages. Such damages are often simply characterized as "pain and suffering." Indeed, pain and suffering developed as an element of damages to compensate people for their physical and emotional suffering. But jurors are often instructed to also consider such things as monetary compensation for disfigurement, loss of parental guidance, loss of parental companionship, loss of moral training from parents, loss of marriage prospects, loss of consortium (e.g., companionship and sexual congress), emotional distress, mental anguish, and loss of enjoyment of life.<sup>55</sup> To calculate non-economic damages, juries are instructed that there is no fixed formula to determine the proper amount and that they must apply their collective wisdom and common sense, being neither stingy nor generous.<sup>56</sup>

Recent research by Lucinda Finley documents some of the non-economic damages suffered by women as a result of medical

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54. If she were to invest the money wisely, the amount would be higher. Jurors are often instructed to consider this possibility and reduce the award to "present value," that is, consider what the award given today will be worth in the future.

55. RONALD EADES, *JURY INSTRUCTION ON DAMAGES IN TORT ACTIONS* §§ 6-18 to 6-20 (3d ed. 1993); THOMAS H. KOENIG & MICHAEL L. RUSTAD, *IN DEFENSE OF TORT LAW* (2001).

56. EADES, *supra* note 55.

negligence.<sup>57</sup> These included injuries due to sexual assault, pregnancy loss, infertility, and gynecological problems, each of which resulted in emotional distress, grief, social adjustment, and an altered sense of self, impaired relationships, and impaired physical capacities such as reproduction and sexual gratification.<sup>58</sup> In some cases failure to diagnose breast cancer in its early stages resulted in the surgical removal of breasts, physical pain, and emotional fears of an untimely death.<sup>59</sup> But such pain and suffering was not limited to females. In one case the misdiagnosis of a twenty-eight-year-old man's stomach pain resulted in partial removal of his bowel and scrotum, leaving him impotent and infertile.<sup>60</sup> In another instance, a doctor used undiluted acid to treat a fifty-four-year-old man's genital warts resulting in severe burns to his scrotum and penis, permanent scarring, and severe pain during sexual intercourse.<sup>61</sup>

Much of the current debate around tort reform is focused on "capping" these non-economic damages at \$250,000.<sup>62</sup> More will be said about this subject later.<sup>63</sup>

### III. THE INCIDENCE AND GENESIS OF CLAIMS AGAINST HEALTH CARE PROVIDERS

#### *A. The Incidence of Claims Is Much Lower than the Incidence of Injury*

One of the most striking findings of the Harvard medical malpractice project is that seven times as many patients suffered from a medical negligence injury as filed a claim.<sup>64</sup> Put in different words, for every seven patients who suffered a negligent injury, just one claim was filed.<sup>65</sup> Claims were also filed in cases in which the

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57. Lucinda M. Finley, *The Hidden Victims of Tort Reform: Women, Children, and the Elderly*, 53 EMORY L.J. 1263, 1281, 1308-12 (2004).

58. *Id.* at 1281.

59. *Id.* at 1310-13.

60. *Id.* at 1286.

61. *Id.*

62. *See, e.g., Connolly, supra* note 1.

63. *See infra* Part IX.

64. WEILER ET AL., *supra* note 21, at 69-76. This book is based on HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION AND PATIENT COMPENSATION IN NEW YORK (1990).

65. WEILER ET AL., *supra* note 21, at 70.

research team of health care providers concluded that there was no negligence.<sup>66</sup> For every doctor or hospital charged with a claim where no negligence was found, however, there were seven valid claims that were not filed.<sup>67</sup>

Earlier research by Danzon, using a database from California, concluded that "at most 1 in 10 negligent injuries resulted in a claim."<sup>68</sup> Similarly, Andrews' study found that, of 1,047 patients who experienced a medical error, only thirteen patients made a claim.<sup>69</sup>

Frank Sloan and Chee Hsieh studied 220 childbirths in Florida in 1987 that involved death or permanent injury to the child.<sup>70</sup> The families of the children were interviewed, and the data were supplemented by an independent medical review of the records by physicians.<sup>71</sup> Of the 220 cases, twenty-three parents sought legal advice.<sup>72</sup> These tended to be cases in which the child suffered very serious injuries and the independent reviewing physicians concluded that negligence was probably involved.<sup>73</sup> Yet, not a single suit was filed in any of the 220 cases.<sup>74</sup> Sloan and Hsieh concluded that:

The lack of claimants among the 220 women whose babies had serious birth-related injuries and the failure of 23 women to obtain [legal] representation runs counter to the "conventional wisdom" that patients sue when they obtain less than a "perfect result." In fact, lawyers filter out many potential claims that injury victims might lose.<sup>75</sup>

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66. *Id.* at 71.

67. Michael Saks, *Medical Malpractice: Facing Real Problems and Finding Real Solutions*, 35 WM. & MARY L. REV. 693, 702, 703 (1994), presents one of the clearest expositions of these findings in a review of WEILER ET AL., *supra* note 21. In further calculations from the Weiler et al. data, Saks points out that the probability of a health care provider being sued for a negligent injury is 0.029 whereas the probability of being sued for a non-negligent injury is 0.0013. Saks, *supra*, at 715.

68. DANZON, *supra* note 28, at 24.

69. ANDREWS, *supra* note 32, at 12.

70. Frank A. Sloan & Chee Ruey Hsieh, *Injury, Liability, and the Decision to File a Medical Malpractice Claim*, 29 LAW & SOC'Y REV. 413 (1995).

71. *Id.* at 418.

72. *Id.* at 430.

73. *Id.* at 428.

74. *Id.* at 430.

75. *Id.*

Legal scholars and social scientists have attempted to understand why people make claims, why people fail to make claims, and the general process of "disputing."<sup>76</sup> Claims that end up in court are only the tip of the iceberg. A fraction of negligent injuries result in grievances, and just a fraction of grievances result in claims.<sup>77</sup> The vast majority of claims are settled, either by a payment to the claimant or by the claimant dropping the claim.<sup>78</sup> The remaining fraction—between seven and ten percent in medical malpractice cases—are actually adjudicated by a judge or jury.<sup>79</sup>

One of the reasons for the failure to claim is that the injured party does not discover that medical negligence was the cause of the injury. Andrews found that some physicians did not include errors in the hospital records because they wanted to avoid litigation.<sup>80</sup> Since patients have an illness that caused them to seek treatment in the first place, it is easy for them to believe that an injury is a natural outcome of the treatment.<sup>81</sup> Other research has indicated that mass media claims that Americans will sue at the drop of a hat are false.<sup>82</sup> In fact many people are reluctant to sue because of widely shared beliefs that it is improper to do so.<sup>83</sup> When medical accidents occur there is some evidence that if doctors apologize or express sympathy for an adverse outcome and the injury is not too serious, patients do

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76. See, e.g., Marc Galanter, *Real World Torts: An Antidote to Anecdote*, 55 MD. L. REV. 1093 (1996); William L.F. Felstiner et al., *The Emergence and Transformation of Disputes: Naming, Blaming, Claiming*, 15 LAW & SOC'Y REV. 631 (1980-81); Herbert M. Kritzer, W.A. Bogart, & Neil Vidmar, *The Aftermath of Injury: Cultural Factors in Compensation Seeking in Canada and the United States*, 25 LAW & SOC'Y REV. 499 (1991); STEPHEN DANIELS & JOANNE MARTIN, CIVIL JURIES AND THE POLITICS OF REFORM 114-35 (1995).

77. Galanter, *supra* note 76, at 1099-02.

78. *Id.* at 1100-01.

79. VIDMAR, *supra* note 3, at 24-25.

80. ANDREWS, *supra* note 32, at 7.

81. Many medically proper treatments for illnesses nevertheless contain small risks of injury or death. These "iatrogenic" injuries need to be distinguished from negligent injuries.

82. See, e.g., Taylor & Thomas, *supra* note 6; Daniel S. Bailis & Robert J. MacCoun, *Estimating Liability Risks with the Media as Your Guide*, 80 JUDICATURE 64 (1996); Galanter, *supra* note 76.

83. See, e.g., David M. Engel, *The Oven Bird's Song: Insiders, Outsiders, and Personal Injuries in an American Community*, 18 LAW & SOC'Y REV. 551 (1984).

not sue.<sup>84</sup> But there is an additional problem, namely the need to find a lawyer to take the case.

#### IV. OBSTACLES TO FILING A LAWSUIT, THE NEED FOR A LAWYER, AND THE CONTINGENCY FEE SYSTEM

A patient injured through medical negligence has a number of daunting hurdles to overcome. The best way to illustrate the issues is with a hypothetical example, based roughly on the facts of a real case.

##### *A. The Case of John Worker*

Assume John Worker, age 35, made \$40,000 per year in his construction job. He has a wife and two young children. His total assets include \$10,000 in savings and \$15,000 of equity in his home, but like many Americans he does not carry health insurance. During medical treatment for a benign tumor, Mr. Worker incurred a serious injury that required six months of hospitalization. Despite his eventual recovery, the injury will prevent him from working for the rest of his life. In addition, he has partial paralysis on the right side of his body and chronic pain severe enough to frequently require strong painkillers. Furthermore, assume the following:

1. Negligence has occurred, or, more properly, it *appears* that negligence has occurred, because "negligence" is a legal concept that has to be admitted by the defendant or proved in court.
2. The uncontested economic losses to Mr. Worker are:
  - a. Past medical bills (intensive care and rehabilitation): \$300,000
  - b. Future medical bills resulting from injury, at \$15,000 per year, for his life expectancy of thirty-nine years to age seventy-four: \$585,000
  - c. Past income lost during year of recovery: \$40,000
  - d. Future income loss to age sixty-five at \$40,000 per

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84. See, e.g., Marlynn L. May & David B. Stengel, *Who Sues Their Doctors? How Patients Handle Medical Grievances*, 24 LAW & SOC'Y REV. 105, 110-11(1990).

year for twenty-nine years, plus expected inflation/promotion adjustments: \$1,200,000

e. *Total economic losses*: \$2,125,000

Assume the defendant physician contests the claim of negligent injury. To prove negligence and obtain compensation Mr. Worker must:

1. Request, receive, and review his medical records;
2. Determine the appropriate law and the appropriate court venue for a lawsuit;
3. File a lawsuit and pay the required filing fees;
4. Find and retain a medical expert (or experts) to review the medical records and who is willing to testify that negligence was the cause of the injury. Mr. Worker will probably also need an expert to testify about the degree of his disability and an economic expert to testify about his future medical and financial losses;
5. Pay those experts (fees of \$500 per hour or more are common for the medical experts);
6. Take the depositions (examination under oath, prior to trial, to learn the basis of the opinions) of the defendant's experts. This includes paying the experts' hourly fees for deposition time and travel costs to wherever they are located;
7. Perhaps have to retain additional experts in light of what is learned from the defendant's experts during discovery;
8. Prepare all of this information for trial;
9. Pay his experts who testify at trial for their time and travel costs;
10. Incur additional costs, e.g., court fees.

None of that guarantees Mr. Worker will receive any money. As discussed below, about forty percent of medical malpractice lawsuits are dropped before the case goes to trial, and doctors win approximately three of every four cases tried before juries. In addition, litigation expenses add up. In complicated trials it is not unusual for the plaintiff to incur costs of \$100,000 to \$300,000 for experts and associated expenses!

Like many Americans, Mr. Worker doesn't understand the law or know how to file his case, find experts, or conduct depositions (even if he were physically able). And he doesn't have money to pay the experts (let's say \$200,000 in his case). Mr. Worker will, therefore, have to find and retain a lawyer.

*B. Plaintiff Lawyers and the Contingency Fee System*

Continuing with our hypothetical example, assume:

1. Mr. Worker finds a lawyer who investigates his case. Mr. Worker most likely will need a specialist in medical malpractice litigation, because proving medical negligence is often very complex and difficult. The investigation will entail a thorough review of the case that includes an initial screening, and hiring of one or more medical experts to review the files and assist the lawyer in understanding the specific medical issues in the case, a necessary requirement in order to negotiate with the defense lawyers and examine and cross-examine expert witnesses at trial. The investigation will possibly take the lawyer many weeks of research (with salaried paralegals and secretaries). Many hours may be spent in these endeavors before the lawyer even decides medical negligence has occurred and files a lawsuit. After filing the lawyer will face additional court filings, hours or even days of depositions (pre-trial examinations of plaintiff and defense experts and other witnesses, including Mr. Worker). There is also likely to be travel to perhaps distant locations to depose these witnesses. The lawyer will also spend hours drafting motions on the law and responses to motions from defense lawyers. Some of these pretrial activities may entail appearances before the trial judge. In Mr. Worker's case trial time is estimated at two weeks. During trial, the lawyer may possibly spend eighteen hour days in actual trial time and preparation. In complex cases the lawyer may often need to retain co-counsel (also paid, of course) to handle the workload. It is likely that the defendant will have multiple lawyers and the plaintiff lawyer cannot afford to be outgunned.



2. The lawyer agrees to advance \$200,000 to pay the experts and agrees to work the case on a contingency fee basis, that is, on a contract that specifies there will be no financial cost to Mr. Worker if he loses his case against the doctor.
3. In return, the specialist lawyer asks for 33% of Mr. Worker's verdict recovery if the case settles before trial and 40% if the case goes to trial.<sup>85</sup> The contract may specify an even higher percentage of recovery, perhaps 45%, if Mr. Worker wins but the defendant appeals the verdict to a higher court, entailing additional time and expense for the lawyer. (Keep in mind that there is a 40% chance that the claim will have to be abandoned before trial and only about a 25% chance of prevailing if the case is decided by a jury. A loss of Mr. Worker's case will result in the lawyer losing the monetary investment and perhaps the many hours of legal work.)
4. There will be a substantial delay before the claim is resolved. Research indicates that, for medical malpractice cases, three to six years elapse between injury and payment to the plaintiff.<sup>86</sup> Trial cases, which tend to be at the far end of this estimate, may be even longer if the defense appeals the verdict.<sup>87</sup>

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85. The 40% is a figure used by some North Carolina lawyers. In other states the figure is 33%. See HERBERT M. KRITZER, RISKS, REPUTATIONS, AND REWARDS: CONTINGENCY FEE LEGAL PRACTICE IN THE UNITED STATES 289 n.20 (2004). In Wisconsin and some other states the fees in medical malpractice cases are limited by law to a sliding scale. *Id.* Thus, in Wisconsin the fee for cases recovering \$1 million or less is limited to 33% and amounts over \$1 million are limited to 20%. *Id.* The Florida Constitution limits contingent attorney fees in medical malpractice to 30% of the first \$250,000 recovered and 10% of everything above that amount. See FLA. CONST. art. I, § 26.

86. Neil Vidmar et al., *Uncovering the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DEPAUL L. REV. (forthcoming 2005).

87. THOMAS H. COHEN, BUREAU OF JUSTICE STATISTICS, NO. NCJ 206240, CIVIL JUSTICE SURVEY OF STATE COURTS, 2001: TORT TRIALS AND VERDICTS IN LARGE COUNTIES, 2001 9 (2004) (finding that 27.7% of medical malpractice trials with plaintiff winners were appealed by defendants).

*C. More About Retaining a Lawyer*

Recall that Sloan and Hsieh<sup>88</sup> showed that, of twenty-three potential claimants who sought legal advice, all had difficulty finding a lawyer willing to take their case.<sup>89</sup> Research by Herbert Kritzer examined the decisions of plaintiff lawyers to take or decline cases.<sup>90</sup> Because lawyers working on a contingency fee basis have their own time and money at stake, they tend to carefully screen cases and weed out those that have minor injuries, low damages potential, or a low potential of winning at trial.<sup>91</sup> In ordinary cases lawyers may decline as many as nine cases in ten; in medical malpractice cases the proportion of declined cases may be even higher.<sup>92</sup> Economic reality drives lawyers' decisions to accept or reject cases.

Combined with the factors of patients not discovering that they are victims of negligence or patients' reluctance to sue even if negligence is discovered, lawyers' rejection of cases helps explain the low claiming rates found in the Harvard study and subsequent studies.<sup>93</sup> Patients who find a lawyer and file lawsuits are more likely to have suffered a serious injury and to have a reasonable likelihood of prevailing on liability and demonstrating serious economic damages.

If the plaintiff wins some readers of this Essay may view the big percentage of the recovery that is taken by the plaintiff lawyer as unfair. Without a lawyer, however, the patient would receive nothing. Kritzer's research, moreover, suggests that when the rewards of winning cases are spread over the losses incurred when plaintiffs do not prevail, the result is an average hourly fee that is comparable to that of other professionals.<sup>94</sup> Of course, some lawyers

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88. Sloan & Hsieh, *supra* note 70.

89. *Id.* at 418 (noting that although 23 victims discussed filing a claim with a lawyer, none filed a malpractice claim).

90. KRITZER, *supra* note 85; *see also* VIDMAR, *supra* note 3, at 49–92 (analyzing variables related to cases that resulted in trial).

91. *See generally* KRITZER, *supra* note 85 (discussing a thorough study of the contingency fee client screening process).

92. Kritzer's research on cases in general indicates that, as a result of these hurdles to a successful litigation outcome, plaintiff's lawyers screen out approximately ninety percent of cases at the point of initial contact by the potential client. *See id.* at 67–89 (discussing medical malpractice in particular at 87–88).

93. *See supra* notes 23–35 and accompanying text.

94. KRITZER, *supra* note 85, at 218 (“[T]he typical contingency fee

who have greater skills and experience are more successful than other lawyers. Those lawyers average greater income, just as specialist doctors make more than non-specialist doctors.

#### *D. Defense Lawyers*

Digressing briefly, defense lawyers are typically paid on an hourly basis rather than by a contingency fee and do not assume the costs of litigation. They are paid by the doctor's liability insurer regardless of whether the case is won, lost, or settled. The doctor's liability insurer bears the litigation costs even when a claim is dropped or results in no payment after a jury trial. Cumulatively, these litigation costs are not trivial, running into thousands or millions of dollars annually.<sup>95</sup>

#### V. TRIAL BY JUDGE AND JURY

If Mr. Worker does file a lawsuit, he and his lawyer must anticipate the possibility of a jury trial. Trial by judge and jury is at the center of the controversy about medical malpractice and the tort system.<sup>96</sup> Juries are accused of being pro-plaintiff, incompetent to evaluate the experts who testify at trial, moved by sympathies for persons with severe injuries regardless of negligence, and overly generous or erratic in making damage awards.<sup>97</sup>

Note the phrase "trial by judge and jury," because the judge's role in a trial is ignored by most critics of the jury system. The trial judge presides over the trial and hears and sees the same evidence as the jury. Before the jury's verdict can be recorded as a legal judgment, the judge must agree that the evidence was sufficient to support the verdict. If the judge disagrees on the issue of negligence, he or she can set aside all or parts of the verdict by invoking the common law power of "judgment notwithstanding the verdict." The parties then face the prospect of a new trial if they want to contest the judgment. If the judge believes that the amount of damages is too high, the amount can be reduced through the legal device called

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practitioner can expect . . . 90 percent of cases . . . to produce a fee premium on the order of 25 to 30 percent of what market-rate hourly fee work generates.").

95. Vidmar et al., *supra* note 86.

96. See CTR. FOR JUSTICE & DEMOCRACY, *supra* note 13, at 12 (noting that insurers blame jury awards for price jumps).

97. VIDMAR, *supra* note 3, at 7.

“remittitur.” If the plaintiff is unwilling to accept the reduced award, the judge can order a new trial. Even if the judge agrees completely with the jury, the defendant can still appeal the verdict to a higher court. In the appellate court, a panel of judges might adjust the verdict or order a new trial. Judges use these powers on a regular basis.<sup>98</sup> Thus, the phrase “trial by judge and jury” correctly reflects the fact that the jury verdict is not the final word. The jury’s decision can be overturned or modified by the trial judge or appellate court judges.

### *A. Plaintiffs Lose Most Jury Trials*

Many studies have examined win rates in medical malpractice trials and their findings contradict widespread beliefs about jury verdicts. For example, The Bureau of Justice Statistics systematically sampled jury verdicts in 1992, 1996, and 2001 in courts representing the seventy-five most populous counties in the United States.<sup>99</sup> Of the 7,948 tort cases that reached trial in 2001, there were 1,156 medical malpractice cases in the sample, and ninety-six percent of these were tried before juries.<sup>100</sup> In 1992, plaintiffs won 30.5% of jury trials, but in 2001 the win rate dropped to 26.3%, roughly one case in four.<sup>101</sup> Win rates vary slightly by state.<sup>102</sup> In North Carolina, for example, plaintiffs prevail in about one in five cases.<sup>103</sup>

### *B. Jurors Tend to View Plaintiff Claims With Skepticism*

The assertion that jurors decide cases out of sympathy for injured plaintiffs rather than the legal merits of the case is one of the

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98. For an example, see *id.*, chs. 9–10.

99. CAROL J. DEFRANCES ET AL., BUREAU OF JUSTICE STATISTICS, NO. NCJ-154346, CIVIL JUSTICE SURVEY OF STATE COURTS, 1992: CIVIL JURY CASES AND VERDICTS IN LARGE COUNTIES (1995); CAROL J. DEFRANCES & MARIKA F.X. LITRAS, BUREAU OF JUSTICE STATISTICS, NO. NCJ 173426, CIVIL JUSTICE SURVEY OF STATE COURTS, 1996: CIVIL TRIAL CASES AND VERDICTS IN LARGE COUNTIES, 1996 (1999); COHEN, *supra* note 87.

100. COHEN, *supra* note 87, at 2, tbl.1.

101. *Id.* at 7, tbl.7.

102. DANIELS & MARTIN, *supra* note 76, at 126.

103. VIDMAR, *supra* note 3, at 25; Neil Vidmar, Testimony on Tort Reform and Medical Malpractice, North Carolina House Blue Ribbon Task Force on Medical Malpractice, Raleigh, N.C., Jan 7, 2004 [hereinafter Testimony of Neil Vidmar].

most persistent claims of opponents of civil jury trial.<sup>104</sup> Such claims have been made about malpractice juries in the United States since at least the nineteenth century.<sup>105</sup> Yet, research finds little support for these claims.

Interviews with North Carolina jurors who decided medical malpractice cases showed that jurors viewed the plaintiffs' claims with great skepticism.<sup>106</sup> Jurors expressed their attitudes in two main themes: first, too many people want to get something for nothing, and second, most doctors try to do a good job and should not be blamed for a simple human misjudgment.<sup>107</sup> Indeed, these attitudes were even expressed in some of the cases in which jurors decided for the plaintiff, i.e., concern that the verdict might have an adverse effect on the doctor's practice.<sup>108</sup> This does not mean that in every case jurors held these views. Sometimes, evidence of the doctor's behavior caused jurors to be angry about the negligence.<sup>109</sup> Yet even in these latter cases the interviews indicated that the jurors had initially approached the case with open minds.<sup>110</sup>

Professor Valerie Hans interviewed jurors who decided tort cases, including medical malpractice, as part of a larger study of business and health provider defendants, and she obtained similar findings.<sup>111</sup> Hans concluded that jurors often penalized plaintiffs who did not meet high standards of credibility and behavior, including those who did not act or appear as injured as they claimed, those who did not appear deserving due to their already high standard of living, those with preexisting medical conditions, and

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104. See generally VIDMAR, *supra* note 3, at 3–8 (summarizing criticisms of juries in the tort system).

105. See KENNETH ALLEN DE VILLE, *MEDICAL MALPRACTICE IN NINETEENTH-CENTURY AMERICA: ORIGINS AND LEGACY* 30 (1990).

106. VIDMAR, *supra* note 3, at 169–71.

107. Neil Vidmar, *Empirical Evidence on the Deep Pockets Hypothesis: Jury Awards for Pain and Suffering in Medical Malpractice Cases*, 43 DUKE L.J. 217, 252–54 (1993) (summarizing research on jurors attitudes that revealed juries may give doctors the benefit of the doubt).

108. *Id.* at 262.

109. *Id.* at 252–53.

110. *Id.*

111. VALERIE P. HANS, *BUSINESS ON TRIAL: THE CIVIL JURY AND CORPORATE RESPONSIBILITY* 127–29 (2001).

those who did not do enough to help themselves recover from their injuries.<sup>112</sup>

*C. Jury Verdicts Tend to Be Consistent with Judgments of Neutral Medical Experts*

An important study of medical malpractice litigation by Mark Taragin et al. compared jury verdicts with the judgments of doctors hired by an insurance company to review the medical records to provide a neutral assessment of whether they believed medical personnel had acted negligently.<sup>113</sup> These decisions were confidential and could not be obtained by the plaintiff or used at trial.<sup>114</sup> The research team compared the doctors' ratings with jury verdicts. The jury verdicts tended to be consistent with these assessments.<sup>115</sup> Moreover, the study also found that judgments for the plaintiff were not correlated with the severity of the plaintiff's injury.<sup>116</sup> The results, therefore, are inconsistent with the claim that juries decide for the plaintiff out of sympathy rather than by applying the legal standard of negligence.

*D. Judges Agree With Jury Verdicts*

Some studies asked trial judges to make independent assessments of who should have prevailed in civil cases over which they presided.<sup>117</sup> The judgments were made while the jury was still deliberating and therefore were not contaminated by knowledge of the outcome.<sup>118</sup> The judge's decision was then compared to the jury

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112. Valerie P. Hans & William S. Lofquist, *Jurors' Judgments of Business Liability in Tort Cases: Implications for the Litigation Explosion Debate*, 26 LAW & SOC'Y REV. 85 (1992).

113. Mark I. Taragin et al., *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 ANNALS INTERNAL MED. 780 (1992). Other research bearing on judgments of medical negligence is reported in Henry S. Farber & Michelle J. White, *A Comparison of Formal and Informal Dispute Resolution in Medical Malpractice*, 23 J. LEGAL STUD. 777 (1997); SLOAN ET AL., *supra* note 43, ch. 6.

114. Taragin et al., *supra* note 113, at 781.

115. *Id.* at 782.

116. *Id.*

117. HARRY KALVEN, JR. & HANS ZEISEL, *THE AMERICAN JURY* (1966); Larry Heuer & Steven Penrod, *Trial Complexity: A Field Investigation of Its Meaning and Its Effects*, 18 LAW & HUM. BEHAV. 29 (1994).

118. KALVEN & ZEISEL, *supra* note 117, at 52.

verdict in that case.<sup>119</sup> Although the research did not specifically focus on malpractice juries, the findings indicate that there was high agreement between the judge and the jury.<sup>120</sup> Moreover, in instances when the judge would have decided differently than the jury, the judge usually indicated that, nevertheless, the jury could reasonably have come to a different conclusion from the trial evidence.<sup>121</sup>

Other studies asked large national samples of judges to draw on their professional experience with juries and give a general opinion about jury decisions.<sup>122</sup> The overwhelming number of these judges give the civil jury high marks for competence, diligence, and seriousness, even for complex cases.<sup>123</sup>

#### *E. No Evidence Supports Claims of a "Deep Pockets" Effect*

Closely related to the claim of "jury sympathy" verdicts is the claim that juries are more likely to render verdicts against doctors, hospitals, and corporations, not because they are seen as negligent, but only because the jurors perceive them as having the ability to pay large awards—a so-called "deep pockets" effect. A number of research studies have assessed this hypothesis and find no support for it.<sup>124</sup> This general finding includes experiments that specifically tested for a deep pockets effect in medical malpractice cases.<sup>125</sup>

#### *F. Little Evidence Supports the Claim that Juries Are "Overwhelmed" By Plaintiffs' Experts*

An often-repeated charge is that jurors are overwhelmed by experts, particularly the plaintiff experts, in medical malpractice cases.<sup>126</sup> This confusion and deference to experts, it is alleged, plays to the advantage of plaintiffs because the jury simply defers to the

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119. *Id.* at ch. 5.

120. *Id.* at 56.

121. *Id.* at ch. 34.

122. These surveys are reviewed in Brief of Amici Curiae Neil Vidmar et al. at \*6-\*9, *Kumho Tire Co. v. Carmichael*, 526 U.S. 137 (1999) (No. 97-1709), 1998 WL 734434.

123. *Id.*

124. For a review of this research, see HANS, *supra* note 111 at 178-87.

125. Vidmar, *supra* note 107.

126. See Neil Vidmar, *Are Juries Competent to Decide Liability in Tort Cases Involving Scientific/Medical Issues? Some Data From Medical Malpractice*, 43 EMORY L.J. 885, 885-91 (1994); VIDMAR, *supra* note 3, at 3-8.

plaintiff's experts and allows juror sympathies for the plaintiff to be the basis of their verdict. There is fuzzy logic in this claim, however, because it ignores the fact that defendants also cross-examine plaintiff experts and call their own experts who offer opinions contrary to the plaintiff's experts. Moreover, the defendants typically call more experts than the plaintiff.<sup>127</sup>

Systematic studies of jury responses to experts lead to the conclusion that (a) jurors do not automatically defer to experts and (b) jurors have a basic understanding of the evidence in malpractice and other cases.<sup>128</sup> They understand that the adversary system produces experts espousing opinions consistent with the side that called them to testify.<sup>129</sup> Moreover, they carefully scrutinize and compare the testimony of opposing experts.<sup>130</sup>

A series of case studies reported in *Medical Malpractice and the American Jury* documented the processes by which jurors reached their verdicts.<sup>131</sup> Interviews with jurors indicated that, in general, through collective discussions about the evidence they came to have an essential understanding of the case and the issues in the dispute.<sup>132</sup> While the jurors may not have backgrounds in medicine, they became educated about the basic issues during the trial through the processes of expert testimony from both sides and from cross-examination.<sup>133</sup> Deliberation and collective wisdom produced an understanding that resulted in a justifiable verdict.

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127. Vidmar, *supra* note 126, at 902.

128. Neil Vidmar & Shari Seidman Diamond, *Juries and Expert Evidence*, 66 BROOK. L. REV. 1121 (2001); Sanja Kutnjak Ivković & Valerie P. Hans, *Jurors' Evaluations of Expert Testimony: Judging the Messenger and the Message*, 28 LAW & SOC. INQUIRY 441 (2003); see also Brief of Amici Curiae Neil Vidmar et al., *supra* note 122, at \*10-\*14 (summarizing research on juror competence in complex cases).

129. See sources cited *supra* note 128.

130. Kutnjak Ivković & Hans, *supra* note 128 (examining jurors' reactions to experts who testify in civil trials and finding jurors consider both the message and the messenger in their evaluation).

131. VIDMAR, *supra* note 3, at 127-82.

132. *Id.*

133. *Id.*



*G. Jury Damage Awards Have Increased but There are Multiple Possible Explanations*

The Bureau of Justice Statistics study found that in 2001 the median verdict in medical malpractice trials when plaintiffs prevailed was \$431,000, compared to \$253,000 in 1992.<sup>134</sup> Punitive damages were awarded in four percent of cases,<sup>135</sup> and those tended to involve cases of gross malfeasance, such as sexual assaults on patients.<sup>136</sup>

Multiple reasons may be offered for the increase in damage awards. Juries may have become more generous. Patients may have sustained more serious injuries. Plaintiff lawyers may have become more adept at "proving" damages by using experts who document economic losses better than in the past. An additional possible cause is that the cost of negligent medical injuries and lost income may have increased. During the 1990s medical costs increased 51.7% and general inflation, which is reflected in lost wages, increased 26.2%.<sup>137</sup>

Another possible explanation for the increase is that more cases with claims of more serious injuries were tried to juries in 2001, compared to 1992. This last possible explanation needs elaboration. A recent study of medical malpractice litigation in Florida found that, compared to the first three years of the 1990s, during the first three years of the 2000 decade there were more settled cases involving claims of negligent deaths and fewer cases involving less serious injuries.<sup>138</sup> Given the fact that settlements typically occur only after three to six years, this change in case mix likely occurred during the middle of the 1990s, not at the turn of the new century.<sup>139</sup> The change in types of cases is unlikely to explain all of the increase in awards, but it does appear to be a possible partial explanation.

In short, like many other parts of the medical malpractice

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134. COHEN, *supra* note 87, at 7, tbl.7.

135. *Id.*

136. See KOENIG & RUSTAD, *supra* note 55, at 127–28, 140–45.

137. Finley, *supra* note 57; see also U.S. Dep't of Labor, *supra* note 46.

138. Vidmar et al., *supra* note 86; for similar findings in Texas, see Bernard S. Black et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1998–2002*, U. TEX. L. & ECON. (Research Paper No. 30, at 20, 22, 34–36 (Mar. 2005)), available at <http://papers.ssrn.com/abstract=678601>.

139. *Id.*

controversy, the questions about damages are complex, and at present there are not satisfactory answers to all of these questions.

#### *H. Damage Awards Tend to Correlate With Severity of Injury*

Bovbjerg, Sloan, and Blumstein found that the magnitude of jury awards in a sample of medical malpractice tort cases positively correlated with the severity of the plaintiffs' injuries, except that injuries resulting in death tended to result in awards substantially lower than injuries resulting in severe permanent injury, such as quadriplegia.<sup>140</sup> While Bovbjerg et al. concluded that there was considerable variability within categories of injury severity, later research by Sloan and van Wert provided a plausible explanation for this variability, namely that economic losses vary considerably within each level of injury severity.<sup>141</sup> The economic loss for a quadriplegic who is forty years old with a yearly income of \$200,000 and a family of three young children would ordinarily be much greater than an identical quadriplegic who is retired, widowed, seventy-five years old, has no dependents, and whose annual income never exceeded \$35,000.

Another study of malpractice verdicts in New York, Florida, and California also found that jury awards of prevailing plaintiffs in malpractice cases were correlated with the severity of the injury.<sup>142</sup> Daniels and Martin found a similar pattern.<sup>143</sup>

#### *I. The "Pain and Suffering" Component of Awards*

As noted earlier, the general damages portion of verdicts is often labeled "pain and suffering," and this is an inappropriate label, because some of these elements of damages involve injuries that are not strictly pain and suffering.<sup>144</sup> In medical malpractice cases, for example, negligent administration of a drug that makes the patient permanently psychotic would be a severe trauma that, aside from

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140. Randall R. Bovbjerg et al., *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering"*, 83 NW. U. L. REV. 908 (1989).

141. See Sloan & van Wert, *supra* note 43.

142. Neil Vidmar et al., *Jury Awards For Medical Malpractice and Post-Verdict Adjustments of Those Awards*, 48 DEPAUL L. REV. 265, 287 (1998).

143. DANIELS & MARTIN, *supra* note 76, at 127-37.

144. See *supra* notes 53-61 and accompanying text; see also Vidmar et al., *supra* note 142, at 296-98.

medication and health care, can have many other economic consequences, including diminished job performance.

Interviews with North Carolina jurors who decided medical malpractice cases indicated that jurors considered the effects of disfigurement and emotional trauma on chances for promotion, the likelihood of a marriage dissolving as a result of the injury, and the economic consequences as well as strict pain and suffering.<sup>145</sup> Jury instructions caution jurors that they should not award compensation for general damages when the same element is included in special damages, but these lines of demarcation are often indistinct.<sup>146</sup>

Vidmar, Gross, and Rose's examination of medical malpractice verdicts in New York, Florida, and California found that the general damages portion of awards was positively related to severity of plaintiff injury.<sup>147</sup> That is, the more serious the injury the higher the mean and median levels of general damages. The exception to this trend was that in cases involving death the mean and median awards tended to be substantially lower than in cases of very serious permanent disabilities.<sup>148</sup> That finding is consistent with the Bovbjerg et al. findings.<sup>149</sup> While these verdict statistics provide no information on the actual basis of the jury's decisions, there is no evidence that these decisions result from caprice or unwarranted sympathy.

*Medical Malpractice and the American Jury* describes several experiments in which jurors, with detailed facts about injuries, were asked to award damages for pain and suffering and disfigurement.<sup>150</sup> Senior lawyers, including some retired North Carolina judges, were independently presented with the same facts and asked to indicate their professional judgment about the appropriate award. The data showed that jurors tended to render awards similar to those of legal

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145. Vidmar et al., *supra* note 142, at 274; VIDMAR, *supra* note 3, at 241; see also Neil Vidmar et al., *Damage Awards and Jurors' Responsibility Ascriptions in Medical Versus Automobile Negligence Cases*, 12 BEHAV. SCI. & L. 149 (1994) (posing hypothetical situations to jurors and resulting in jurors not differentially awarding pain and suffering damages across conditions).

146. See, e.g., EADES, *supra* note 55, at 321.

147. Vidmar et al., *supra* note 142, at 281-99.

148. *Id.* at 296.

149. See Bovbjerg et al., *supra* note 140.

150. VIDMAR, *supra* note 3, ch. 19.

professionals. The data also showed that jurors' reasoning on damages was similar to that of the professionals.

*J. Outlier Awards Tend Not to Withstand  
Post-Verdict Adjustments*

Despite the substantial evidence indicating that juries are ordinarily conservative in deciding damages in malpractice cases, there are exceptions resulting in what are commonly labeled "outlier awards."<sup>151</sup>

There are a number of reasons for outlier awards.<sup>152</sup> One is that doctors might contest the case solely on liability and not contest damages at all. The plaintiff, on the other hand, presents the losses through experts who give a high-end version of the plaintiff's losses. The judge instructs the jury to decide damages solely on the evidence but the jurors have only the plaintiff's figures to work with. Despite reservations the jurors follow the judge's instructions and accept the plaintiff's suggested award, because that is the only evidence that they have. In other instances, the defense may call an economist who offers an alternative to the plaintiff's damages estimate; the level of damages may be quite high due to the seriousness of the injury, and the jury might use this as a floor from which damages are estimated. Additionally, in some jurisdictions juries are presented with the gross amount of a loss or of a life care plan that is not reduced to present value.<sup>153</sup>

The final explanation casts the jury in a less favorable light. Specifically, because of the evidence brought out at trial the jurors become so outraged at the negligence of the defendant that they appear to add a punitive component into their compensatory award, contrary to the judge's instructions.<sup>154</sup> These outlier awards are not

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151. See Steve Cohen, *Malpractice: Behind a \$26-Million Award to a Boy Injured in Surgery*, N.Y., Oct. 1, 1990, at 41 (presenting in depth analysis of one particularly large "outlier award"), reprinted in VIDMAR, *supra* note 3, at 95.

152. See VIDMAR, *supra* note 3, at ch. 7.

153. *Id.* at ch. 16.

154. A case study of one such award and its eventual reduction by the trial judge is reported in *Id.* at chs. 9–10. Some other probable cases of jury outrage are reported in Vidmar et al., *supra* note 142, at 287–90.

as frequent as portrayed in the mass media,<sup>155</sup> but they unquestionably do occur.

Nevertheless, research evidence indicates that these verdicts seldom withstand post-verdict proceedings. Two co-authors and I examined malpractice verdicts in New York, Florida, and California to determine what happened to the outlier awards.<sup>156</sup> We observed that there are four main processes by which awards can be reduced. Two of these invoke the "trial by judge and jury" explanation: the judge reduces the award verdict through the legal mechanism of remittitur, or the case is appealed and a higher court reduces the award.<sup>157</sup> Sometimes the sides agree that there was negligence but disagree about the amount of damages and set a high-low agreement prior to trial.<sup>158</sup> Most common of all, the plaintiff and the defendant negotiate a post-trial settlement that is less than the jury verdict.

Our study empirically explored the fate of many of the outlier awards. We found that some of the largest malpractice awards in New York ultimately resulted in settlements between five and ten percent of the original jury verdict.<sup>159</sup> My study of medical malpractice awards in Pennsylvania found a similar reduction.<sup>160</sup> These findings are consistent with earlier research by Ivy Broeder,<sup>161</sup> by researchers at the RAND Corporation,<sup>162</sup> and by researchers at

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155. See, e.g., Bailis & MacCoun, *supra* note 82; Michael McCann et al., *Java Jive: Genealogy of a Juridical Icon*, 56 U. MIAMI L. REV. 113 (2001).

156. Vidmar et al., *supra* note 142, at 280–95.

157. *Id.* at 278.

158. High-low agreements are not uncommon. These occur in some cases in which the plaintiff and defendant cannot close the gap on the amount of a negotiated settlement. They agree to submit the case to the jury under the condition that, if the jury verdict falls below a certain amount, or even if there is a defense verdict, the plaintiff will receive a specified amount of money anyway, and if the verdict is above a specified amount the defendant will pay no more than the figure agreed to before trial. In this way both parties are protected against outlier verdicts that either give the plaintiff little or nothing or, alternatively, expose the defendant to an award that could severely injure finances. The public and even the court may be unaware of the agreement but such arrangements are legal and serve both parties well.

159. Vidmar et al., *supra* note 142, at 287–88.

160. See Neil Vidmar, *Juries and Jury Verdicts in Medical Malpractice Cases: Implications for Tort Reform in Pennsylvania*, unpublished report (Jan. 28, 2002) (unpublished manuscript, on file with the author).

161. Ivy E. Broder, *Characteristics of Million Dollar Awards: Jury Verdicts and Final Disbursements*, 11 JUST. SYS. J. 349(1986).

162. MICHAEL G. SHANLEY & MARK A. PETERSON, RAND: THE INSTITUTE

The National Center for State Courts.<sup>163</sup> Similarly, Merritt and Barry conducted a detailed examination of jury awards in Franklin County (Columbus) Ohio.<sup>164</sup> They documented a number of post-trial reductions in jury awards.<sup>165</sup> For example, a \$12 million award was reduced by the trial judge to \$8.5 million and a \$3 million award was reduced by an appeals court to \$1.5 million.<sup>166</sup>

Plaintiffs are willing to negotiate lesser amounts for three main reasons. First, many plaintiffs would rather have the money immediately than wait the years it would take to get the money if the case were appealed.<sup>167</sup> Second, there is always a risk that an appeals court will reduce the award or even overturn the verdict.<sup>168</sup> Third, most of these outlier awards greatly exceed the medical provider's insurance coverage.<sup>169</sup> While plaintiffs and their lawyers could attempt to foreclose on the defendant's assets, they are very reluctant to do so.<sup>170</sup> Therefore, the plaintiff negotiates a settlement around the limit of the defendant's insurance coverage. High-low agreements, too, usually take cognizance of the upper limits of insurance coverage.<sup>171</sup>

#### VI. TOO MUCH EMPHASIS ON JURIES! CONSIDER SETTLEMENT RATES

In recent research, I and my colleagues studied closed medical malpractice claims in Florida.<sup>172</sup> Florida has required medical liability insurers to file detailed reports of closed medical malpractice claims with the Department of Health since 1975.<sup>173</sup> Our research

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FOR CIVIL JUSTICE, POSTTRIAL ADJUSTMENTS TO JURY AWARDS (1987).

163. Brian Ostrom et al., *So the Verdict Is In—What Happens Next?: The Continuing Story of Tort Awards in the State Courts*, 16 JUST. SYS. J. 97 (1993).

164. Deborah Jones Merritt & Kathryn Ann Barry, *Is the Tort System in Crisis? New Empirical Evidence*, 60 OHIO ST. L.J. 315, 353–55 (1999).

165. *Id.* at 354–55.

166. *Id.* at 354.

167. Vidmar et al., *supra* note 142, at 278.

168. *Id.*

169. *Id.*

170. Tom Baker, *Blood Money, New Money, and the Moral Economy of Tort Law in Action*, 35 LAW & SOC'Y REV. 275, 284–85 (2001).

171. Vidmar, *supra* note 160.

172. Vidmar et al., *supra* note 86.

173. *Id.*

centered on cases closed between 1990 and 2003. A total of 21,809 claims closed with a payment to the claimant during those fourteen years. The study found that 20.2% of paid claims settled without the claimant even resorting to a lawsuit, 6.3% of claims settled in arbitration, and 70.8% settled before a jury verdict, leaving just 2.7% of paid claims that resulted from a jury verdict.<sup>174</sup>

To pursue this insight further, cases involving a million dollars or more were singled out.<sup>175</sup> We found that 10.5% were settled without a lawsuit and 4.6% were settled in arbitration, 77.4% settled before or during trial, and only 7.6% resulted from a jury verdict. Put in the obverse, more than 92% of claims with million dollar payments were settled without a jury. Going further, our study found that thirty-seven of the 831 million-dollar cases resulted in payments over \$5 million. Only two of these involved a jury trial. Five of the 831 cases exceeded \$10 million dollars, but only one was the result of a jury trial; of the remaining four cases one settled in pre-litigation negotiations, and three settled before trial commenced.

Perhaps Florida is different than other states. It is hazardous to generalize because each state has its own unique set of laws and legal culture. Nevertheless, it is interesting to observe that data from the *North Carolina Lawyer's Weekly*, a publication of the North Carolina Trial Lawyers Association, seems roughly consistent with the Florida findings.<sup>176</sup> The data are not systematic, tend to report only large cases, and often do not report the amount of the settlement. Nevertheless, the data show some interesting patterns. As early as the first part of the 1990s there were verdicts and settlements exceeding \$1 million.<sup>177</sup> Over the period from 1990 through 2002, the number of million-dollar-plus settlements exceeded the number

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174. Trial rates for medical malpractice cases usually range between seven and ten percent of lawsuits. These include cases in which defendants prevail, approximately seven or eight trials in ten. See VIDMAR, *supra* note 3, at 39. The data reported here do not include plaintiff verdicts at trial, but they do include cases that never became lawsuits. In short this data uses a different numerator and different denominator than previous studies.

175. The payments were adjusted for inflation so that we could compare earlier cases with later cases.

176. Testimony of Neil Vidmar, *supra* note 103. The same data have been used by the North Carolina Trial Lawyers Association and by Medical Mutual of North Carolina, a doctor-owned liability insurer. *Id.*

177. *Id.*

of million-dollar-plus jury verdicts by a factor of over three to one.<sup>178</sup> The average amounts of \$1 million plus settlements, when settlements were reported, were comparable to the jury awards.<sup>179</sup> A statistical test on the data indicated that the distributions and the magnitudes of payments for jury verdicts and non-jury settlements were not statistically different from one another.<sup>180</sup> In short, the North Carolina findings also indicate that most of the payments exceeding a million dollars involved settlements rather than jury trial.

These findings have a major implication. Whether we are talking about all cases or just million dollar cases, the process by which claims are paid in Florida (and, it appears, also in North Carolina) involves the negotiation table, not the jury room. In Florida, settlements exceeded jury trials by a factor of more than nine to one for million dollar cases.<sup>181</sup> We need to learn why these cases were settled rather than put before juries. Was it a fear of large jury awards—the “shadow effect”—that caused defendants to settle? Alternatively, was the negligence and severity of loss so clear that it made no sense to go to trial because defendants’ liability insurers would incur heavy litigation costs in the face of a likely win for the patient? At this point we cannot say which of these opposing explanations is correct. Both could be correct to some degree.<sup>182</sup> At

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178. *Id.*

179. *Id.*

180. *Id.*

181. Vidmar et al., *supra* note 86.

182. Research by Ralph Peebles et al., *The Process of Managing Medical Malpractice Cases: The Role of Standard of Care*, 37 WAKE FOREST L. REV. 877 (2002), on a sample of insurers’ medical malpractice files indicated that insurers tend to settle cases primarily based on whether their own internal reviews by medical experts indicate the provider violated the standard of care. *Id.* at 879. If they decide the standard was violated, they attempt to settle. *Id.* at 886. Those authors concluded that claims proceed to trial only when the plaintiff cannot be convinced that there was no violation of the standard and cannot extract a reasonable offer from the insurer. *Id.* at 894. An earlier study by Roger A. Rosenblatt & Andy Hurst, *An Analysis of Closed Obstetric Malpractice Claims*, 74 OBSTETRICS & GYNECOLOGY 710 (1989), examined 54 obstetric malpractice claims for negligence. *Id.* For cases in which settlement payments were made, there was general consensus among insurance company staff, medical experts, and defense attorneys that some lapse in the standard of care had occurred. *Id.* at 712. No payments were made in the forty-two percent of cases in which these various reviewers decided there was



the very least the findings strongly suggest that the emphasis on jury verdicts appears misplaced.

## VII. RISING CLAIMS AND RISING COSTS: A COMPLICATED ISSUE

The Florida data also allow us to partly address the question of whether the frequency of malpractice claims has been rising and whether, simultaneously, the costs of payouts also have. This is a complicated issue and a contentious one, so I need to be very cautious and emphasize very important qualifications of our findings.

We found that the number of claims involving payments to the claimant increased between 1990 and 2003.<sup>183</sup> Florida's population also increased at the same time, however, as did the number of licensed physicians.<sup>184</sup> When adjusted for population the number of paid claims per 100,000 residents in 2003 was no higher than in 1990. Similarly, paid claims per 100 licensed physicians also were no higher.<sup>185</sup> This would seem to support consumer groups who say there has been no increase. But wait. Here is the problem.

Doctors and insurers say that the number of claims began to rise steeply around the year 2000 and continued through 2003.<sup>186</sup> Our findings cannot speak to this matter for the following reason. After a claim of negligence is made it usually takes between three and six years before the claim is settled.<sup>187</sup> Thus, if claims began to rise in 2000 through 2003, the rise in paid claims is just beginning to occur now. Also, our data were incomplete regarding claims resulting in no payment. Claims with no payment also incur transaction costs to defend. It is noteworthy that data collected by the National Center for State Courts on a national sample of cases showed that while there was an overall decline in medical malpractice case filings between 1992 and 2001, filings did rise in 2002.<sup>188</sup>

The Florida closed claims data also revealed that, between 1990 and 2003, the inflation-adjusted cost of the average paid claim

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no lapse in the standard of care. *Id.*

183. Vidmar et al., *supra* note 86.

184. *Id.*

185. *Id.*

186. *Id.*

187. *Id.*

188. Nat'l Ctr. for State Courts, Examining the Work of State Courts, 2002: A National Perspective from the Courts Statistics Project 25 (2002), available at <http://www.ncsonline.org>.

showed a modest upward increase.<sup>189</sup> Part of the explanation might be that medical costs, which have increased at rates greater than the Consumer Price Index,<sup>190</sup> are the cause. But there are other explanations. Our data also showed that on average the paid claims, beginning in 2002, included a greater proportion of serious injuries, including death.<sup>191</sup>

One possible explanation for these last findings is that there were more cases of serious injury. An alternative explanation is that the rates of serious injury remained stable but more of the seriously injured patients made claims. Either or both of these explanations might be true, but again we must consider that the time lag from the date of the injury to a settlement is between three and six years. That lag indicates that the jump in serious claims began to occur around 1996 and was only reflected beginning about 2000. Thus, whatever the cause, the genesis of the shift in serious injury claims began to occur in the middle of the 1990s. Thus, the data show that the average payment to claimants increased, but we cannot determine the degree to which the increase was due to inflation or to different mixes of cases being settled.

#### VIII. FRIVOLOUS LITIGATION

Claims about frivolous litigation are based, in part, on findings that in medical malpractice cases doctors prevail in approximately seventy percent of cases that go to trial and that as many as forty percent of cases filed against health care providers ultimately result in no payment to the plaintiff.<sup>192</sup> Additionally, opponents of medical malpractice litigation argue that jury verdicts, especially those involving larger awards, encourage lawyers to file lawsuits in cases that are without merit because doctors and liability insurers will settle claims out of fear of a large and unjustified award if the case goes before a jury.<sup>193</sup> These claims are not supported by research evidence.

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189. Vidmar et al., *supra* note 86.

190. *Id.*

191. *Id.*

192. VIDMAR, *supra* note 3, at 40–41 (reviewing statistics from several studies on settlement rates).

193. See e.g., <http://www.sickoflawsuits.org>.

*A. Liability Insurers Tend to Not Settle  
Frivolous Cases*

In interviews that I undertook with liability insurers in North Carolina and other states, the most consistent theme from them was: "We do not settle frivolous cases!"<sup>194</sup> The insurers indicated that there are minor exceptions, but their policy on frivolous cases was based on the belief that, if they ever begin to settle cases just to make them go away, their credibility will be destroyed, and this in turn will encourage more litigation.<sup>195</sup>

*B. Cases Dropped by Claimants Before Trial Are  
Not Necessarily Frivolous*

*Medical Malpractice and the American Jury* reports that despite upfront screening by plaintiff lawyers, there is still a lot of uncertainty about whether negligence has occurred.<sup>196</sup> Negligence can usually only be determined after a lawsuit is filed, depositions are taken, and expert opinions are obtained. As documented in that book, research into the files of liability insurers showed that this is as true of the defense side as it is of the plaintiff side: lawyers for the defendants and their insurers get conflicting opinions as to whether negligence has occurred. Sometimes, after an extensive process of consulting with experts and taking depositions, it becomes reasonably apparent that no legal negligence occurred, or that, in any event, the case is not winnable because of the costs of pursuing it. At this juncture plaintiff lawyers tend to drop the case. In North Carolina nearly forty percent of filed cases were dropped on these grounds.<sup>197</sup> Again, the point to be made is that it makes little economic sense for a plaintiff lawyer to continue to invest time and money in a case that is unlikely to win. Occasionally lawyers misjudge the merits of cases and continue to pursue them, but far more often they are dropped.

Thus, since both the plaintiff and the defendant are faced with uncertainty, it is inappropriate to call the vast majority of dropped

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194. VIDMAR, *supra* note 3, at chs. 7 & 8; see also Rosenblatt and Hurst, *supra* note 182.

195. VIDMAR, *supra* note 3, at chs. 7 & 8.

196. *Id.*; SLOAN ET AL., *supra* note 43, at 164-85 (reporting systematic data that are consistent with my conclusions).

197. VIDMAR, *supra* note 3, at chs. 3 & 4.

cases "frivolous." Rather, they should be labeled "non-meritorious" cases in recognition of the fact that both sides took them very seriously at the beginning of the lawsuit.

*C. Doctor's High Win Rates at Trial Do Not Mean the  
Lawsuit was Frivolous*

As discussed earlier, statistics indicate that, nationwide, doctors prevail in as many as seventy percent of cases that go to trial.<sup>198</sup> Nevertheless, a plaintiff's loss at trial is not grounds for concluding that the litigation was "frivolous."<sup>199</sup> Cases that go to trial are ones where negligence is uncertain. As discussed above,<sup>200</sup> when pretrial investigation shows that the case is clearly not winnable, lawsuits tend to be dropped before trial. On the other hand, cases with clear negligence tend to be settled, particularly if the parties can negotiate the amount of damages.<sup>201</sup> Thus, only "close" cases tend to go to trial.

There are a number of possible explanations, other than non-merit, as to why doctor win rates at trial are so high.<sup>202</sup> One reason is that jurors generally tend to be skeptical of plaintiff claims and essentially place a burden on the plaintiff that is greater than the legally appropriate "balance of probabilities" standard.<sup>203</sup> Another is that plaintiffs often have a more difficult time obtaining and hiring the experts, relative to the defense.<sup>204</sup> It is also important to observe that, in many instances, plaintiffs who lost at trial against one doctor nevertheless obtained settlements from other doctors who had been named in the lawsuit.<sup>205</sup> This might suggest that medical negligence occurred in the case, albeit that at trial the jury did not think that the evidence against the remaining defendant or defendants was sufficient to find liability. On the other hand, it is possible that despite insurers' insistence that they do not make settlements for non-meritorious claims, in some instances they may decide that a

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198. See *supra* note 192, and accompanying text.

199. VIDMAR, *supra* note 3.

200. Part VIII.B.

201. See *supra* note 182, and accompanying text.

202. VIDMAR, *supra* note 3.

203. *Id.* at 169–71 (discussing juror attitudes toward plaintiffs and defendants); see *supra* Part VIII.B.

204. VIDMAR, *supra* note 3, at 72–76, 86–87.

205. *Id.* at 33–34.

modest and confidential settlement payment avoids bad publicity for the doctor and saves expensive litigation costs. Such a decision could explain why some doctors settle.<sup>206</sup>

## IX. SOCIAL POLICY CONSIDERATIONS: CAPS ON NON-ECONOMIC DAMAGES

### *A. Plaintiff's Recovery and Effects on Insurance Premiums*

Many proposals for tort reform blame juries for excessive and unjustified pain and suffering awards and advocate a cap of \$250,000 on these damages.<sup>207</sup> As discussed above, there is more to non-economic damages than pain and suffering, such as disfigurement, loss of moral support and guidance from a parent. Aside from the value judgment of whether someone with a debilitating injury or these other losses can be adequately compensated by that cap, there are other issues that need to be considered.

First, as described above, only a small percentage—about 8 percent—of million-dollar payments result from jury awards, the target of the pain and suffering caps.<sup>208</sup> In Mississippi, as an illustration, the public and legislative debate centered on the need for a cap because of the asserted large number of million-dollar jury awards.<sup>209</sup> Yet Mississippi actually had only slightly more than one million-dollar medical malpractice award each of those years.<sup>210</sup> A cap is unlikely to have any major effect on malpractice costs if just slightly over one million-dollar jury verdict occurs per year, although it might have some effects on cases with lesser injuries.

Studies undertaken to assess the effects of caps on jury awards and on any reductions in doctor's liability insurance premiums

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206. Many doctors want to avoid the publicity, the emotional pressures, and the time from her practice that a trial would entail. However, in other cases doctors may insist on going to trial to clear their reputation. *Id.*

207. *See supra* note 1.

208. *See supra*, Part V.I & J.

209. Neil Vidmar and Leigh Ann Brown, *Tort Reform and the Medical Liability Insurance Crisis in Mississippi: Diagnosing the Disease and Prescribing a Remedy* 22 MISS. C.L. REV. 9-46 (2002). A subsequent article that examines the Mississippi "liability crisis" in great detail and arrives at a similar conclusion is E. Farish Percy, *Checking Up on the Medical Malpractice Liability Insurance Crisis in Mississippi: Are the Reforms the Cure?* 73 MISS. L.J. 1001 (2004).

210. Vidmar & Brown, *supra* note 209; Percy, *supra* note 209.

generally show that the caps did reduce the amount of the plaintiff's recovery. For example, a study of California jury trials occurring between 1995 and 1999 by RAND's Institute for Civil Justice showed that California's MICRA cap of \$250,000 on non-economic damages reduced awards about twenty-five percent in injury cases and over fifty-one percent in cases involving death.<sup>211</sup>

A United States Government Accounting Office report showed that states with caps on medical malpractice damages tended to have lower premiums for doctors and that rate increases were lower in states with caps.<sup>212</sup> The report also concluded, however, that it is not possible to show a direct link between caps and premiums because there are other factors that distinguish states with and without caps.<sup>213</sup> Some states without caps, for example, have the lowest premiums of all.<sup>214</sup> One important other factor appears to be state regulation of insurance premiums. In short, the evidence that caps reduce or slow doctors' premium increases is at best unclear.

*B. Injured Claimants Often Receive Less Than  
Actual Economic Losses*

Debates about medical malpractice reform often ignore effects of the injuries on the lives and finances of plaintiffs. In their study of birth and emergency room injury awards, Sloan and his colleagues compared the plaintiffs' economic losses to the amount actually received.<sup>215</sup> On average, for cases that were settled prior to trial, plaintiffs received only forty-eight percent of their losses.<sup>216</sup> Plaintiffs in cases that went to trial did better than plaintiffs in settled cases, ultimately receiving twenty-two percent more than their estimated economic losses.<sup>217</sup> Sloan and Hsieh further concluded that persons with the most severe injuries were least likely to receive adequate compensation.<sup>218</sup> Cases that go to trial before juries are

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211. NICHOLAS M. PACE ET AL., CAPPING NON-ECONOMIC AWARDS IN MEDICAL MALPRACTICE TRIALS: CALIFORNIA JURY VERDICTS UNDER MICRA, at xvii-xx (RAND Institute for Civil Justice 2004).

212. U.S. GEN. ACCOUNTING OFFICE, *supra* note 5.

213. *Id.* at 7.

214. *Id.* at 37.

215. SLOAN ET AL., *supra* note 43, at Chapter 9.

216. *Id.* at 195.

217. *Id.*

218. Frank Sloan & C. Hsieh, *Variability in Medical Malpractice Payments:*

usually different than cases that are settled, so precise comparisons between settled and trial cases are not possible. Plaintiffs settle at a discount to avoid the costs and uncertainties of trial by judge and jury as well as the fact that they receive needed money immediately rather than months or years later.<sup>219</sup> Nevertheless, the Sloan data do suggest that on average, plaintiff lawyers, served their clients well when cases did go to trial.

After conducting their detailed analyses, Sloan et al. concluded that "few claimants received payments far above the mean for their stage of resolution categories. The fact that even plaintiffs who were successful at verdict received payments only moderately higher than economic loss contradicts the notion that courts make very excessive awards in medical malpractice cases."<sup>220</sup>

Studdert et al. examined the effects on injured patients of California's \$250,000 cap on non-economic damages.<sup>221</sup> Their findings indicate that reductions under the cap affected the patients with the most severe injuries.<sup>222</sup> They concluded:

Imposition of greater reductions on more severe injuries may be justified if compensation for this particular group of injuries were especially prone to excess. In fact available evidence suggests the reverse is true: Plaintiffs with the most severe injuries appear to be at the highest risk for inadequate compensation. Hence, the worst-off may suffer a kind of "double jeopardy" under caps.<sup>223</sup>

*C. Injured Plaintiff Outcomes with Caps: Back  
to Mr. Worker*

We can begin to grasp the recovery rate of injured parties by returning to our hypothetical case of John Worker. Let us assume that after six years of waiting Mr. Worker's case finally comes to trial, and the jury determines that the doctor was negligent. Assume further that the jury awards Mr. Worker's full economic losses of

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*Is the Compensation Fair?* 24 LAW & SOC'Y REV. 997, 1025-29 (1990).

219. *Id.*

220. SLOAN ET AL., *supra* note 43, at 195.

221. David Studdert et al., *Are Damage Caps Regressive? A Study of Malpractice Jury Verdicts in California*, 21 HEALTH AFFAIRS 54 (2004).

222. *Id.* at 63.

223. *Id.* (citations omitted).

\$2,125,000 plus \$750,000 for non-economic losses ("pain and suffering") yielding a total award of \$2,875,000.

However, in Mr. Worker's state there is a cap on non-economic damages. The judge reduces the non-economic loss to \$250,000, thus deducting \$500,000 and entering a judgment of \$2,375,000. That is still a lot of money, but now calculate Mr. Worker's net recovery after litigation expenses:

a. Final award	\$2,375,000
b. Lawyer fee @ 40%	(\$950,000)
c. Litigation expenses	<u>(\$200,000)</u>
Mr. Worker's net recovery:	\$1,225,000

Net recovery, however, needs to be compared to actual economic losses to determine how Mr. Worker has fared. Thus we calculate as follows:

a. Original economic loss	\$2,125,000
b. Net recovery	<u>\$1,225,000</u>
c. Mr. Worker's economic loss:	(\$900,000)

In short, even though Mr. Worker incurred \$2,125,000 in medical and income losses, in the end he will have an actual \$900,000 economic loss.

If there had been no cap on non-economic damages or if there had been a cap with a higher limit, say \$750,000 (not incidentally the amount the jury awarded in this hypothetical example), Mr. Worker would have received the jury's original award of \$2,875,000. The additional \$500,000 that he would have received would almost have, to use a common lawyer phrase, "made him whole." Well, not quite; he would still be \$600,000 short, but that is considerably less than being \$900,000 short.

Note that even with the full amount of the jury verdict before the cap adjustment, Mr. Worker would still effectively have received no compensation for his pain and suffering and other non-economic losses. Whatever the jury's reasoning about the appropriateness of the non-economic damages when it awarded him \$750,000, in actual effect the non-economic award would have offset most of Mr. Worker's litigation expenses. Put bluntly, the pain and suffering component would have defrayed most of his litigation expenses. In other words the pain and suffering component would have mostly



paid for his lawyer and the experts that were absolutely necessary to get him compensation for his economic losses.

People will differ as to whether a cap system is fair under the circumstances of the hypothetical Mr. Worker's case. Those who believe that caps on pain and suffering reduce liability insurance premiums will reasonably argue that the unfairness to Mr. Worker is offset by the need to protect doctors so that they can serve the public. Others will take a different view and feel that the injustice to Mr. Worker trumps doctor interests.

Some may further feel that Mr. Worker's lawyer reaped a windfall in this case. That feeling must, however, be judged against the fact that the lawyer risked her own \$200,000 to litigate the case, and if Mr. Worker had not prevailed, that money would have been lost. Additionally, the lawyer devoted many hours to the case and had to pay secretaries, paralegals, and office expenses. Moreover, the lawyer had less than a forty percent chance of prevailing in the case.

I chose a forty percent figure for the lawyer's contingency fee for trial. I noted earlier that by law or by customary practice, some lawyers claim only thirty-three percent and in other instances lawyer fees are determined by a graduated scale with diminishing fee returns as the settlement or award increases. Some lawyers calculate the percentage of recovery after litigation expenses are deducted. Under these conditions Mr. Worker's net recovery would be a little higher. The reader can do the math.

A more important consideration is that this is not all of the story. Mr. Worker has some additional claims against his jury award.

## X. SUBROGATION CLAIMS/LIENS AGAINST MR. WORKER'S AWARD

### *A. Liens Against the Award*

Let us add a factor that has not been addressed at all in the current debate about tort reform. Because Mr. Worker, like millions of Americans, had no health insurance to cover his post-injury care and because his wife received only minimum wage from her part-time job, Mr. Worker's state's Medicaid program paid for his post-injury medical bills. Recall that he incurred \$300,000 in immediate post-injury care and that, during the five and one-half years between his discharge from the hospital and the trial verdict, he incurred

medical expenses of \$15,000 per year for a total of \$82,500.

The state's Medicaid administrator placed a \$382,500 lien against Mr. Worker's award to recover those costs. Thus, we need to recalculate what Mr. Worker will actually put in the bank:

- |   |                    |
|---|--------------------|
| a. Net recovery after litigation expenses | <u>\$1,225,000</u> |
| b. Minus Medicare lien                    | (\$382,500)        |
| c. Net recovery after Medicaid lien       | \$842,500          |

The \$842,500 will make Mr. Worker independent for a time. If he is wise he will invest that money, but consider that both the consumer price index and the medical inflation index will also increase during the subsequent years, likely offsetting investment gains. Consider that after six years of litigation and a jury verdict he is now forty-one years old and will need \$55,000 per year for his income loss (\$40,000) and medical expenses (\$15,000). In about fifteen years, at age fifty-six, the money will be exhausted (\$842,500 / \$55,000 per year = 15.3 years). Thus, he may have to go back on Medicaid or Medicare and perhaps on welfare.<sup>224</sup>

#### *B. More About Medicare and Medicaid Liens and Subrogated Claims*

My example about the injured Mr. Worker is hypothetical, but in a study of the Indiana Medical Malpractice Act, Kinney et al. reported anecdotal data bearing on the economic losses incurred by some patients injured by medical malpractice.<sup>225</sup> A forty-three year-old woman who lost function in her left arm and both legs and lost both bladder and bowel control during an operation in 1981 was consequently confined to a nursing home for the rest of her life. She

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224. This hypothetical case does not consider other matters that would complicate the financial picture. It is possible that due to the injury his life expectancy will be shortened and his widow will inherit the money. The example has also not considered any welfare payments to Mr. Worker and his wife and children, or to debts for living expenses accrued during the five years between the injury and the jury verdict. On the other hand, Mr. Worker's health may deteriorate as a result of his injury and he may need nursing home care, exponentially increasing his annual medical expenses.

225. Elanor Kinney, William Gronfein & Thomas Gannon, *Indiana's Medical Malpractice Act: Results of a Three Year Study*, 24 IND. L. REV. 1275, 1276-77 (1991). Indiana's statute limits total recovery of all losses, economic and non-economic, in medical malpractice cases to \$750,000. *Id.*

was eventually awarded an annuity of \$400,000 in 1987.<sup>226</sup> After litigation expenses, lawyer fees, and Medicaid liens, the woman reported that the remaining balance would not cover her nursing home expenses for one year.<sup>227</sup>

In research leading to *Medical Malpractice and the American Jury*, I investigated a case involving a child suffering a brain injury at birth who died two and a half years later.<sup>228</sup> The county paid for his medical expenses during his brief life, approximately \$900,000 in today's dollars.<sup>229</sup> Medicaid claimed all of that amount on behalf of its taxpayers.<sup>230</sup> Recently in North Carolina a confidential source described to me a medical malpractice case involving the death of an elderly man and a settlement of about \$350,000. Medicare took back approximately \$300,000.

In American law a health insurer is under statutory or contractual obligation to pay the expenses of the person that it insures if that person is ill. This obligation includes not only government-sponsored plans such as Medicare and Medicaid but also private health insurance plans, including HMOs and private insurance like Blue Cross/Blue Shield. If a third party (a doctor in the present context) is found to be responsible for the illness or injury, the health insurer has a right to collect the money that it has paid out for the insured patient subsequent to the negligent injury. The basis of the law is built on reasoning that (a) if not for the negligence of the third party the health insurer would not have had to pay the bills and (b) it is not fair if the health insurer pays for the injured person's medical expenses and the injured person then collects and pockets the money for the same expenses.

In fact, the health insurer has the right to sue the doctor under the patient's name.<sup>231</sup> The legal term "subrogation" is the right of the insurer to "stand in the shoes" of the injured person.<sup>232</sup> A "lien"

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226. *Id.* at 1301-02 n.169.

227. *Id.*

228. VIDMAR, *supra* note 3.

229. *See id.* at 28-29.

230. *See id.*

231. THOMAS J. LAWRENCE & JOHN M. RUSSELL, ERISA SUBROGATION 4 (2000); JEFFREY D. MAMORSKY, HEALTH CARE BENEFITS LAW (2004); APPLEMAN ON INSURANCE LAW AND PRACTICE (2d Ed.) (2004) at 141.1 Subrogation Rights.

232. LAWRENCE & RUSSELL, *supra* note 231, at 4.

against the award when the injured person sues involves the same principle. Similar subrogation rights apply to income insurers like workers' compensation and to a private employer that is contractually obligated to pay a worker's salary during illness or injury.<sup>233</sup>

Both Medicare and Medicaid are administered by the Center for Medicare and Medicaid Services (CMS).<sup>234</sup> Medicare covers persons over age sixty-five and Medicaid generally provides for persons of any age who are disabled or who have dependents and have no other source to pay medical bills.<sup>235</sup> Under the provisions of the Employee Retirement Income Security Act (ERISA), the administrators of Medicare and Medicaid are required to assert subrogation rights and collect any money they have paid for the patient if that patient recovers money from a third party.<sup>236</sup>

Herbert Kritzer examined the importance of claims against recovery in a study of plaintiff lawyers in Wisconsin.<sup>237</sup> Wisconsin health insurers who pay for medical expenses of an injured person are very aggressive in seeking to recoup their money from any settlement or jury award paid by a negligent party.<sup>238</sup> Kritzer found that these third party claims occur in small cases as well as large ones.<sup>239</sup> Plaintiff lawyers often negotiate an agreement with the public or private insurer to take only a percentage of the monies owing in order to make it affordable for them and their clients to undertake a lawsuit.<sup>240</sup> If the amounts of liens are too great, the reduced potential recovery weighed against litigation time and expenses may cause the lawyer to decline taking the case. This insight provides an additional explanation for why injured patients sometimes cannot find legal representation.

We do not have comprehensive data on the frequency and magnitude of liens against medical malpractice verdicts and settlements. Every state and the federal government have laws

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233. See KRITZER, *supra* note 85, at 161–63.

234. See <http://www.cms.hhs.gov/researchers/projects/APR/2004/facts.pdf>.

235. *Id.*

236. ERISA, 404(a)(1); 29 U.S.C.A. § 1104(a)(1); see *Liss v. Smith*, 991 F. Supp. 278 (S.D.N.Y. 1998).

237. KRITZER, *supra* note 85, at 160–69.

238. *Id.* at 161.

239. *Id.*

240. See *id.*

providing subrogation or other recovery rights for taxpayer-supported health plans and private insurance plans, however.<sup>241</sup> Unquestionably, subrogated claims play a significant role in medical malpractice litigation. In our John Worker case the lien was relatively modest, but in many instances it may be substantially greater, as in the two real life examples from Indiana and North Carolina described above. Additionally, if Mr. Worker and his family needed to take welfare assistance to pay their living expenses or if the medical injury occurred while Mr. Worker was covered under a workers' compensation scheme, those agencies might also have liens against the money he received.

*C. Public Policy Issue: Taxpayers as "Silent Plaintiffs"*

In addition to the obvious points that prevailing plaintiffs may have to surrender some of their net recovery to a public or private health insurer and that lawyers cannot economically afford to take cases with low potential recovery, a more subtle point is that taxpayers indirectly have a stake in the medical malpractice outcome through their financial underwriting of Medicaid, Medicare, and other taxpayer-supported public welfare organizations. Only if Mr. Worker and his lawyer file and win a lawsuit do the taxpayers get their money back. The issue then is who should pay in these instances, the negligent health care provider or taxpayers?

The hypothetical example of Mr. Worker has admittedly simplified some issues. Kritzer, for example, found that third parties, such as representatives of Medicaid, are sometimes very involved in negotiations with the plaintiff's lawyer at early stages of lawsuits.<sup>242</sup> He pointed out that plaintiff lawyers frequently negotiate with public and private health insurers in order to obtain agreements to take only a percentage of the dollars they are due.<sup>243</sup>

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241. See generally, MAMORSKY, *supra* note 231 (describing these laws in more detail).

242. See KRITZER, *supra* note 85, at 160-64.

243. *Id.* at 162-63. MAMORSKY, *supra* note 231, at 5-100-5-106 (reporting that in some instances plaintiff lawyers have crafted settlement agreements specifying that the payment is primarily for non-economic damages, greatly reducing the amount that Medicaid or Medicare can recover when a statute specifies that subrogation applies only to economic damages, but this tactic has not always succeeded). In cases of extreme hardship, where recovery would lead to especially harsh results, Medicaid and Medicare will sometimes waive

The issue of subrogation has not been raised in the current debate on tort reform, but it is an important public policy issue. Specifically, taxpayers sometimes hold interests in common with medical malpractice plaintiffs. Provocatively put, the issue is whether taxpayers should assume the burden of medical negligence or whether the negligent health care provider, through liability insurance, should assume it.

#### XI. CAPS ON PAIN AND SUFFERING

The case of Mr. Worker draws attention to the consequences of a cap of \$250,000 on pain and suffering for plaintiffs. It suggests that such caps will restrict the amount of recovery for injured plaintiffs and may even affect their ability to find a lawyer to take their case. Research studies of states with caps have tended to confirm that caps reduce the amount recovered by plaintiffs,<sup>244</sup> but questions of fairness are raised. Research by Lucinda Finley examined the consequences of caps on the allocation of plaintiff recoveries in California, Florida, and Maryland by looking at jury verdicts and calculating the discrepancy between what the jury awarded and the amount the plaintiff would recover under caps.<sup>245</sup> She found that the major effects would fall most heavily on children, women, and elderly people because their losses are more likely to be non-economic losses, albeit often devastating and tragic.<sup>246</sup>

David Studdert and his colleagues conducted a study of California jury verdicts to assess the impact of California's \$250,000 cap on non-economic damages and concluded as follows:

Analysis of proportional reductions shows that the burden of caps tends to fall on injuries that cause chronic pain and disfigurement but do not lead to declines in physical functioning that would generate lost work time or high health care costs. . . . Notwithstanding their limited

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their right to recovery under the Medical Care Recovery Act. *See* KRITZER, *supra* note 85, at 164.

244. *See* MARTIN D. WEISS, WEISS RATINGS, INC., *MEDICAL MALPRACTICE CAPS: THE IMPACT OF NONECONOMIC DAMAGE CAPS ON PHYSICIAN PREMIUMS, CLAIMS PAYOUT LEVELS AND AVAILABILITY OF COVERAGE* 7-8 (2003), available at <http://www.weissratings.com/malpracticecap.asp>.

245. Finley, *supra* note 57.

246. *Id.* at 1265-66.

economic impact, the injuries involved are by no means trivial.<sup>247</sup>

Even if there is some unfairness, we need to consider if that is a price to be paid if the effect of caps is to reduce doctors' liability insurance premiums so that they can continue serving the public health needs. This is a fair cost-benefit analysis, but the problem is that research does not support the proposition that caps will reduce those premiums. In a 2003 report the Government Accounting Office concluded that there was no solid evidence to support the proposition.<sup>248</sup> While some states with caps had lower premiums than states without caps, some states without caps had premiums that were lower than the capped states.<sup>249</sup> A report by Weiss Ratings, a respected insurance analyst, found that caps on pain and suffering did not result in insurers reducing doctors' insurance premiums.<sup>250</sup> In 2003 GE Medical Protective Company, the nation's largest medical malpractice insurer, reported to the Texas Department of Insurance as follows: "Non-economic damages are a small percentage of total losses paid. Capping non-economic damages will show loss savings of 1.0%."<sup>251</sup> The company also said that a provision in Texas law allowing for periodic payments of awards would provide a savings of only 1.1%. Medical Protective eventually raised the rates on its physician policyholders.<sup>252</sup> In California, which has had a cap of \$250,000 since 1975, GE Medical Mutual sought an increase of 29.2% in liability insurance premiums.<sup>253</sup>

In short, caps on pain and suffering do not appear to be the answer to lowering doctors' liability insurance premiums.

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247. David Studdert et al, *supra* note 221, at 63 (footnotes omitted); see also Frank Sloan & C.R. Hsieh, *Variability in Medical Malpractice Payments: Is the Compensation Fair?* 24 LAW & SOC'Y REV. 601 (1990) (pointing out a similar inequity in pre-1990 cases).

248. See U.S. GENERAL ACCOUNTING OFFICE, *supra* note 5.

249. See *id.* at 37.

250. WEISS, *supra* note 244, at 3.

251. See <http://www.consumerwatchdog.org/insurance/rp/rp004689.pdf>.

252. THE NATION, October 26, 2004.

253. *Id.*

## XII. ALTERNATIVE EXPLANATIONS AND REMEDIES

In the introduction to this Essay I drew attention to its limited focus on negligently injured patients, the contingency fee system, and juries. There are many other issues in the controversy over medical malpractice litigation, and they should not be minimized. Once again, it is important to state that this Essay does not take issue with the claim of the American Medical Association and other parties urging "tort reform" that beginning about the year 2000 some physicians began experiencing severe difficulties in obtaining affordable medical liability insurance.

The issue then is what is the cause of the crisis, if not excessive jury awards? Liability insurance companies claim that the frequency of claims and the amounts that they have to pay for those claims and the litigation expenses associated with defending them have increased.<sup>254</sup> Research by the National Center for State Courts found that while there was a decline in medical malpractice case filings from 1997 to 2000, filings increased in 2001 and 2002.<sup>255</sup> This may be a cause of present concerns of liability insurers since they have to increase their financial reserves and anticipate greater total payouts in three to six years as these cases mature and are settled. They will also have to incur more transaction costs to defend the claims.

In contrast consumer groups and trial lawyers vehemently argue that the cause of the present crisis is not the tort system.<sup>256</sup> They argue that in the first half of the 1990s competing insurance companies irresponsibly underpriced liability premiums in a price war when bond markets yielded high returns on company reserves.<sup>257</sup> In 2000 when the financial investment markets were not so favorable and insurers had to begin paying for the malpractice claims made in the middle of the decade, they had to increase premiums to

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254. See American Medical Association, *supra* note 5; see also GOVERNOR'S SELECT TASK FORCE ON HEALTHCARE PROFESSIONAL LIABILITY INSURANCE, Florida, January 29, 2003 at 69–116 [hereinafter GOVERNOR'S SELECT TASK FORCE], available at <http://www.doh.state.fl.us>.

255. Brian J. Ostrom et al., *National Center for State Courts, Examining the Work of State Courts*, 2002, available at <http://ncsonline.org>.

256. See Ctr. for Justice & Democracy, *Where's The Crisis? Has America Been Duped By The AMA?*, available at <http://centerjd.org>.

257. Studdert et al., *supra* note 3, at 286.



compensate.<sup>258</sup> There is evidence to support this claim.<sup>259</sup> A recent detailed study of the medical malpractice “liability crisis” in Mississippi shows that in contrast to companies that invested their reserves in the bond market, MACM, a doctor-owned mutual that is Mississippi’s largest medical liability insurer, invested a larger percentage of its reserves in the stock market than most insurers.<sup>260</sup> MACM was hit particularly hard financially when the market turned down at the beginning of the twenty-first century.<sup>261</sup>

This Essay does not address other reforms that were implemented or proposed, such as limiting plaintiff lawyer fees, implementing pre-trial screening panels to weed out non-meritorious cases, or changing “joint and several liability” rules in which a health care provider who is judged to have only minor responsibility for an injury nevertheless has to pay most or all of the damages caused by another health care provider.<sup>262</sup> Short but excellent reviews of most of the medical malpractice issues are contained in two articles in the *New England Journal of Medicine* and are highly recommended for readers who seek more information on this topic.<sup>263</sup> There also some informative general books on the subject.<sup>264</sup>

### XIII. CONCLUDING THOUGHTS

Despite drawing attention to myths about the tort system, reflective readers of this Essay will see that the American tort system is very far from ideal. It involves considerable expense to both patients and their lawyers, to malpractice liability insurers, and ultimately to health care providers through insurance premiums. Many dollars are devoted to transaction costs, not only by injured patients but by liability insurers who cumulatively spend millions of

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258. Thomas Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 52 DEPAUL L. REV.393 (forthcoming 2005).

259. See *id.*; Studdert et al., *supra* note 3; Jay Anghof, *Challenging the Need for Medical Mutual’s Malpractice Rate Increase*, TRIAL REPORTER 8 (Winter 2004).

260. Percy, *supra* note 209, at 1060–65.

261. *Id.* at 1063–65.

262. See Studdert et al., *supra* note 3, for a brief discussion of tort reforms in this context.

263. *Id.*

264. E.g., IRA WILLIAMS, *FIRST, DO NO HARM: THE CURE FOR MEDICAL MALPRACTICE* (2004).

dollars defending non-meritorious claims and claims where liability may be clear but agreement cannot be reached on the amount of damages. Many negligently injured patients receive no compensation. There is evidence that patients with relatively less serious injuries who do make claims are overcompensated while patients with more serious injuries are undercompensated for their losses.

Being sued and even the prospect of being sued causes health care providers much emotional anguish.<sup>265</sup> There are arguments that the threat of lawsuits causes doctors to engage in defensive medicine, ordering unnecessary tests and other procedures that drive up the costs of health care. There appears to be equivocal evidence to support the defensive medicine argument, and the counter argument has been made that some defensive medicine is good, such as helping to ensure that doctors order tests that may detect problems at early stages of a disease rather than in later stages.<sup>266</sup> On the other hand, there is no solid evidence that the tort system actually deters negligent medical treatment.<sup>267</sup> In fact deterrence is a difficult phenomenon to prove. David Hyman and Charles Silver have provided a detailed and insightful analysis of the relationship between the tort system and the quality of health care<sup>268</sup> that is too lengthy to discuss here but is recommended for interested readers.

If the tort system were abolished for medical malpractice there would be no problem with doctors and hospitals obtaining affordable liability insurance—they would not need *any* professional liability insurance. However, an alternative system would be needed to cover the medical and income losses of patients who are injured when undergoing medical treatment. Some authors proposed a “no-fault” system in which injured patients would be compensated under a system like workers’ compensation plans, but those schemes have raised issues regarding enormous costs to taxpayers and have been

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265. GOVERNOR’S SELECT TASK FORCE, *supra* note 254, at 79–102.

266. See Michelle Mello & Troyen Brennan, *Deterrence of Medical Errors: Theory And Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595 (2002) (reviewing these issues).

267. *Id.*

268. David Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. (forthcoming 2005).

proven to be politically not viable.<sup>269</sup> If the United States had universal health care coverage, some of the problems of economic losses incurred by patients following medical negligence would be relieved, because medical costs, if not income losses, would be covered. Universal health care, too, has also proven politically not viable.

Beginning about 1982, with on pressure from Congress, Medicare payments for health care provider services have been increasingly tightened.<sup>270</sup> HMO restrictions on payments also affect physician incomes. In discussions with physicians, I found they complain of increasing pressures on the way they practice medicine and the impact of these pressures on their incomes. This issue is also ignored in the malpractice debate, but it may well be an important contributor to physician reactions to the problems of the affordability of liability insurance.

Medical malpractice and medical malpractice litigation are complicated subjects, but public debate has often involved misunderstandings, particularly with respect to negligently injured patients and the judge and jury system. This Essay has presented information intended to correct some of those misunderstandings and raise an additional issue about who should bear the cost of medical negligence. But the reader must bear in mind that it is selective and does not cover all of the many issues. Medical malpractice litigation is a complex problem for which simple answers are insufficient and which, in any event, involves some tough value choices!

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269. See Jeffrey O'Connell, *A Proposed Remedy for Mississippi's Medical Malpractice Miniseries*, 22 MISS. C. L. REV. 1 (2002); Paul Weiler, *The Case for No-Fault Medical Liability*, 52 MD. L. REV. 908 (1993).

270. See [http://research.aarp.org/health/fs45r\\_medicare.html](http://research.aarp.org/health/fs45r_medicare.html); [http://www.medpac.gov/publications/congressional\\_testimony/072302\(WM\)local\\_input\\_p\\_rices.pdf](http://www.medpac.gov/publications/congressional_testimony/072302(WM)local_input_p_rices.pdf); [http://www.medpac.gov/publications/congressional\\_reports/Mar04\\_Table\\_Contents.pdf](http://www.medpac.gov/publications/congressional_reports/Mar04_Table_Contents.pdf).